State of Maryland / Department of Health and Mental Hygiene

					Cer	tificate d	of Death		Reg. No.	1 6	001
Dhusisian	1. Decedent's Name (F	First, Middle, La	ast)					2. Dete of D Month	eeth Day	Year	3. Time of Death
Physician /Medical	Cara	Petrir)ii					April	10	ાર્વેંવૈવ	6:45 ar
Examiner	4a Facility Name (If no			er)			4b. City, To	wn, or Location of Dee		ty of Death	
		tospit	al					rmore		Itimor	
Funeral Director	5. Social Security Number 216-04-8865	5	Sex 7. 1 □ M 2 💢 F	Age (In yrs. las	Ven	If Under 1 Your Months De	ear If Under	Min. 8. Date of B (Month, D	irth Pay, Year) 1982	9. Birthpl Coun Mary	lace (State or Forei try) land
ž	Usual Residence of De 10a. State 10	Ob. County		10c. City,	Town or Lo	cation				10	Od. Inside City Limit
t or 28a-f sho be notified Director	PA A	Allegan	y	Gib	sonia						1 ☐ Yes 2 🕅 N
23a or 2			Blvd.			10f. Zip Coo			10g. Citizen o		
natural, or items 23a or 28e-f show diest Examiner must be notified at eted by Funeral Director	3 ☐ Widowed 4 ☐		12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	No No		Vas Decedent Yes, specify (gin? (Specify Yes or N , Puerto Rican, etc.)	В	aca - Americ lack, White, on hity:white	etc.
"natural", adica Ex leted by	15 (Specify)	. Decedent's E	ducation ade completed)		16a. Deced	ent's Usual Ockind of work de	cupation one during most	of working	16b. Kind of	Business/Inc	lustry
than than omple	Elementery/Seconde		College (1-4		Studer	OO NOT use re	tired)	of norming	Sch	001	
エキューの		st, Middle, Last)				18. Mothe	r's Name (First, Middle	e, Maiden Sum	ame)	
	John H. Pet	trini					Cynth	ia Esposit	0		
th and Mental 7 is marked of traumatic ever	19a. Informent's Name	Pelationship ((Type, Pnint)		19b. Mailin	g Address (St		or or Rural Route Num		m, State, Zip	Code)
573	Cynthia Esp	oosito :	Haskins(r	nother)	10511	old E	abcock	Blvd. Gibs	onia. E	A 1504	14
frem 27 in other tra	20a. Method of Disposi			20b. Pla	ce of Dispos	sition (Name of	f	Date		n - City or To	
	1 X Burial 2 C 4 Donation 5			ate		norial		4/13/99	Cumberl	and M	Maryland
Project Project	21. Signature of Funera			pario			dress of Facilit				_
on a sur	Ben	e Oy	m. Bo	les				John M. I cester St.	, Annar	olis,	MD 21401
	23a. Part1. Enter the c shock, or heart fa	disease, o li com allure. List only	plications that cau one cause on eac	sed the death. h line.	Do not ente	er the mode of	dying, such as	cardiac or respiratory	arrest,		Approximete Interval Between
nysician											Onset and Death
Medical xaminer	Immediate Cause (Findisease or condition	al	a meni	09000	mal	menn	sitis				24 hours
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physician end s the burial-transit	Sequentially list condit	tions,	Ų.	Due to (or a	s a conseq	uenca of):					
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sic sic	Part II. Other significan	nt conditions	contributing to deal	h but not result	ing in the ur	nderlying caus	e given In Part I	. 23b. Die	d tobacco use	contribute to	the cause of deat
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b ed		i									
should should									s an autopsy formed?	CO	ere autopsy finding: eileble prior to mpletion of cause death?
page 2								1.5	Yes 2 No		Yes 20 No
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8 2 0	examiner?	to medical	Hospital:		210		Other	of Death (Check only			
this cral dir	1 Yes 2 No		28a. Date of		R/Outpetien 8b. Time of		4LI NU	rsing Home 5 Res	sidenca 6 ∐0 e how injury occ		y)
After fune	1 Netural 5	5 ☐ Pending	(Month,	Day Year)	Injury		Injury at Work? 1 ☐ Yes 2 ☐		a now injury occ	,41160	
tor: the	2 Accident 3 Suicide 6	investigation Could not b	00 - 01	Injuny At hom	o form etc				(Street and Nu	mhar or Burn	Il Route Number,
THE PACE	4 Homicide	determined	building	Injury - At hom, etc. (Specify)	ie, ierm, str	set, rectory, or	ice	City or To	own, State)	niber or riure	i Houle Wallion,
5 O = 40	29e. Certifier 15	Certifying Pi	hysician: To the be	est of my knowle s of examinatio	edge, death	occurred et th	ne time, date an	d placa, and due to the	e cause(s) end	menner es s	teted.
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thin 24 hours efter the Funeral Direct mpletely filled in by Wedical Certif		a ad an will				29C. Li	cense number		29d. Date sig	nea (Month,	Duy, 1087)
within 24 hours effect To the Funeral Direct completely filled in by Medical Certif	29b. Signature and title	of certifier		0		10.	70 19 7		0 1	10 1	000
To the Funeral Di completely filled ii		of certifier Quele	chen m	0		D3	38127		April	10 1	999
To the Funeral By Completely filled in Medical Cel		of certifier Julie Derson who	-	O of deeth (Item 2	3a) (Type, I		38127			10 1	999
within 24 hours of To the Funeral DI Completely filled ii	29b. Signature and title	guela Jucka Derson who	-		(3a) (Type,		38127	Battime		10 l	999 nd 21215

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** April 8, 1999 3:45 P.M. John Peterson Brock /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 680 Americana Dr. Apt. 58 Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) Oct. 23, 1914 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 186-05-0071 84 Parnassus, VA. Director Usual Residence of Decedent 10a State 10h Counts 10c City Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Example man be notified at 1 Ves 2 □ No Maryland Anne Arundel Director Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 680 Americana Dr. Apt. 58 21403 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S.
Armed Forces?
1 ₾ Yes, 2 □ No 1942—
If Yes, Give
Year or Dates: 1945 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: by White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) USDA Agricultural Economist permit. Pages 1 and 2 should be file Department of Heelth end Mental Hy Important: If Nem 27 Is marked othe any Injury or other traumatic event, pages. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Bradshaw Peterson Elizabeth Brock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) V. Virginia Peterson/Wife 680 Americana Dr. Apt. 58 Annapolis, MD. 21403 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Maryland Veteran's Cem. 4/12/99 Crownsville.MD. 4 □ Donation 5 □ Other (Specify) 21. Signatury Funeral Service Licensee 22. Name and Address of Facility 2973 Solomons Island Rd. Edgewater, MD 21037
Approximate ause of the death. Do not enter the mode of dying, such as cardiac or respiratory errest,
Approximate George P. Kalas Funeral Home als P.11. Enter the disease, or complication, or heart failure. List only one **Physician** Liver conier /Medical Immediate Cause (Final GM disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Physician/Medical Due to (or es e consequence of): attending pl signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown the polym dien 1 | Yes 2 | No þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? r this certificate has 1 Yes 25 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 8 Other (Specify) P 1 Yes 250 No funerel 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 Accident Injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide **E**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Medicai 29b. Signeture and title of centier 29c. License number 29d. Date signed (Month, Day, Year) 032036 30. Name and address of person who ited cause of death (Item 23a) (Type, Print) 15 Dowl Drue Chater Md 2/6/9 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registra

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filed within 72 hours efter

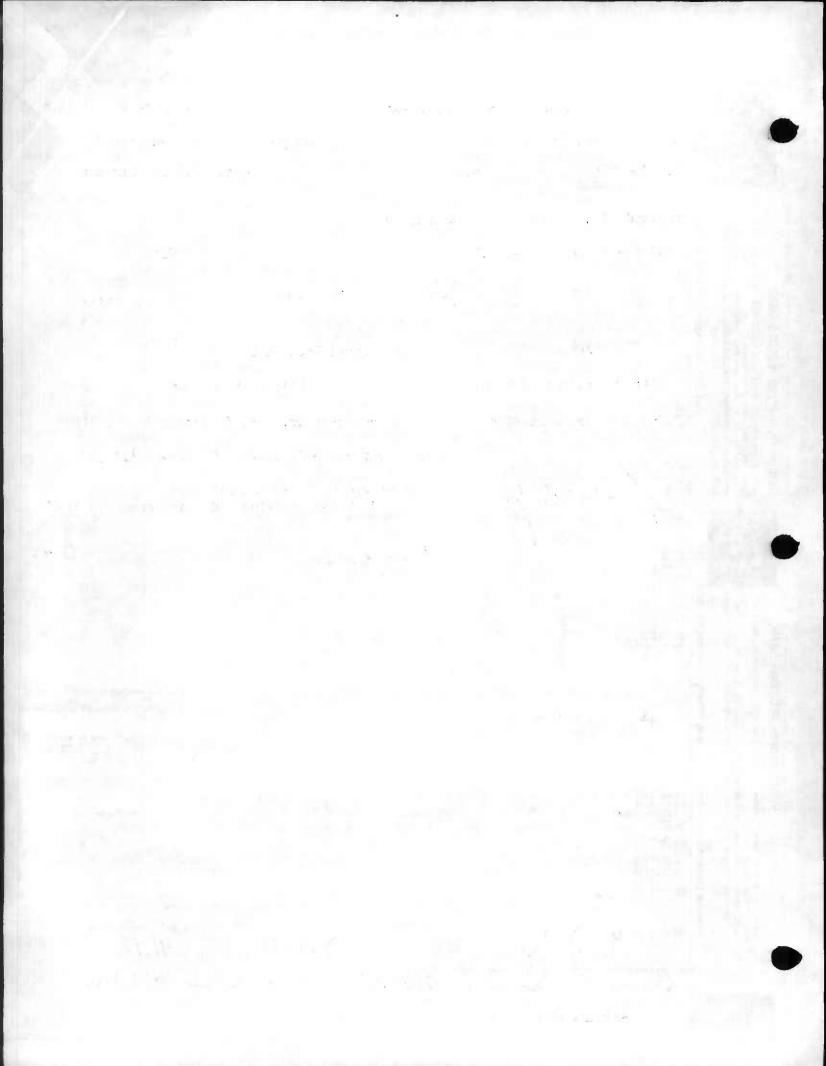
The law requires that the death certificate be executed

Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifice

Division of Vital Records, P.O. Box 68760,

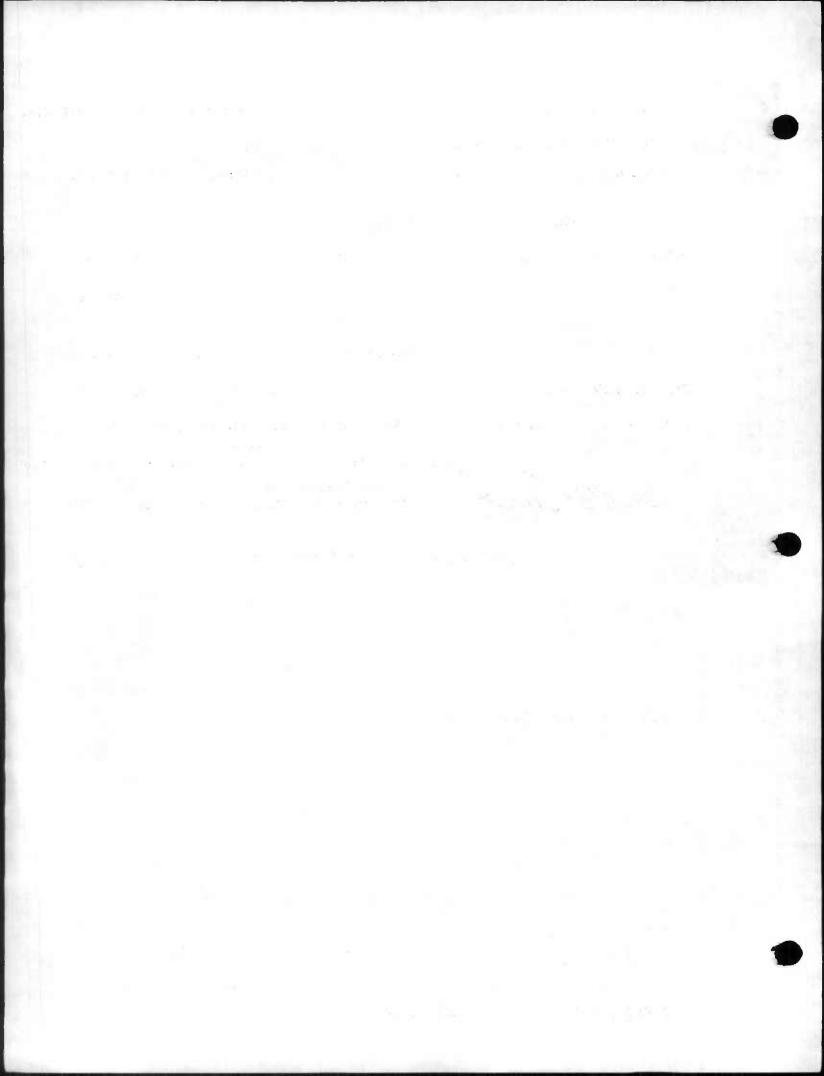
Hygiana.

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physici	ian	1. Decedent's Name (<i>Pirst, Middle, Last)</i>	2. Dete of Deal Month	th Day	Yeer	3. Time of Death
/Medic	cal	EDNA MARIE POOLE 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or L	April ocation of Deeth	17 199 4c. County		9:00 P.N
EXAMIL	ier					
Francis		Calvert Manor Healthcare Center Rising S 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Cec		ne (State or Earnin
Funeral Director		220-20-7085 1 M 2 F 95 Yrs. Months Days Hours Min. Usual Residence of Decedent	8. Date of Birth (Month, Dey, November	3, 1903	Mary.	ce (State or Foreig y) Land
№ m		10e. Stete 10b. County 10c. City, Town or Location			100	d. Inside City Limit
naturel', or items 23a or 28a-f show	tor	Maryland Harford Havre de Grace				1⊠ Yes 2□N
r 28s	Director	10e. Street end Number 10f. Zip Code	1	Og. Citizen of	Whet Countr	y?
39 0		712 South Union Avenue 21078		TT-34-	1 0	
E 2	Funeral	11. Marital Status 12. Was Decadent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-		d Stat	
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a la	P	15. Decadent's Education 16e. Decadent's Usual Occupation		16b. Kind of B	usiness/Indu	strv
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nd Mental merked of umetic eve	ToE	John D. Burkentine Annie E	lizabeth	Lundo	ren	
end l		19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rur				code)
of Health e Item 27 Is other trai		Marjorie M. Burkentine / Niece 241 Kirks Mill Lane, N	orth Eas	st. MD	21901	
		20a. Method of Disposition 20b. Place of Disposition (Neme of	Dete	20c. Location -		
Department of Important: If any Injury or once.		1 & Burial 2 Cremation 3 Hemovel from State	pril 21 1999 H	Jaura d	o Crac	e, Mary
orta Inju		21. Signature of uneral Service dicesses 22. Name and Address of Facility		lavie u	e Grac	.e. mary.
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99-2103-510 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. crn State of Maryland / Department of Health and Mental Hygiene Nicholas G. Perry AMEND ITEMS: #27, 28B-F PER MEO G777 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Day Month **Physician** Year Gauge Perry Nicolas April 12, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Hospital Baltimore
If Under 24 Hrs.
Hours Min.

| A. Date of Birth (Month, Day, Year) | July 5, 1997 N/A Baltimore If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days XXM 2 F Months 220-49-0291 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. other than "natural", or flems 23s or 28s-f show out, the Medical Examiner must be notified at Maryland Talbot Trappe Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29304 Howell Point Road 21673 US Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, altimore, Maryland 21215-0020 Black, White, etc. 1. Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White g 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) is marked other permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy important! If New 27 is marked ofths any Injury or other 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kurt M. Perry Denise Setzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kurt M. Perry Father 29304 Howell Point Road Trappe, Maryland 21673 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removel from State 4/16/99 4 ☐ Donation 5 ☐ Other (Specify) Old Trinity Churchyard Church Creek, Maryland 22. Name and Address of Facility
Thomas Funeral Home, P.A. 21. Signaturii Funeral Service Licensee 700 Locust Street Cambridge, Maryland 21613 23a. Part Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical rowning Examiner Due to (or as a consequence of): Examiner be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical Dua to (or as a consequence of): 98 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy

Be

1⊠ Yes 2□ No

25. Was casa referred to medical

2 No 19 Yes 2□ No 26. Place of Death (Check only one) Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify)

111 Penn Street, Baltimore, Maryland 21201

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? UNRYOWN 5 Randing investigation 1 QNaturel 4-7-99 1 Yes 2 Accident 6 Could not be 3 Suicide 4 Homicide

28d. Describe how injury conurred SUBJECT
INTO POND 202 No 281 Location (Street and Number or Rural Route Number, 2 678 on Town, State) Howell's Point Route

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) BACK YARD OF RESIDENCE 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier Druns but no 29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) April 13, 1999

3. Time of Death

08:35 A.M

1 Yes X No

30, Nama and address of person who completed cause of death (Item 23a) (Type, Print) Chute, no

31. Date filed (Month, Day, Year)

32. Registrar's Signature 5 1999

DHMH 16 Rev 6/95

certificate

2

edical Certification:

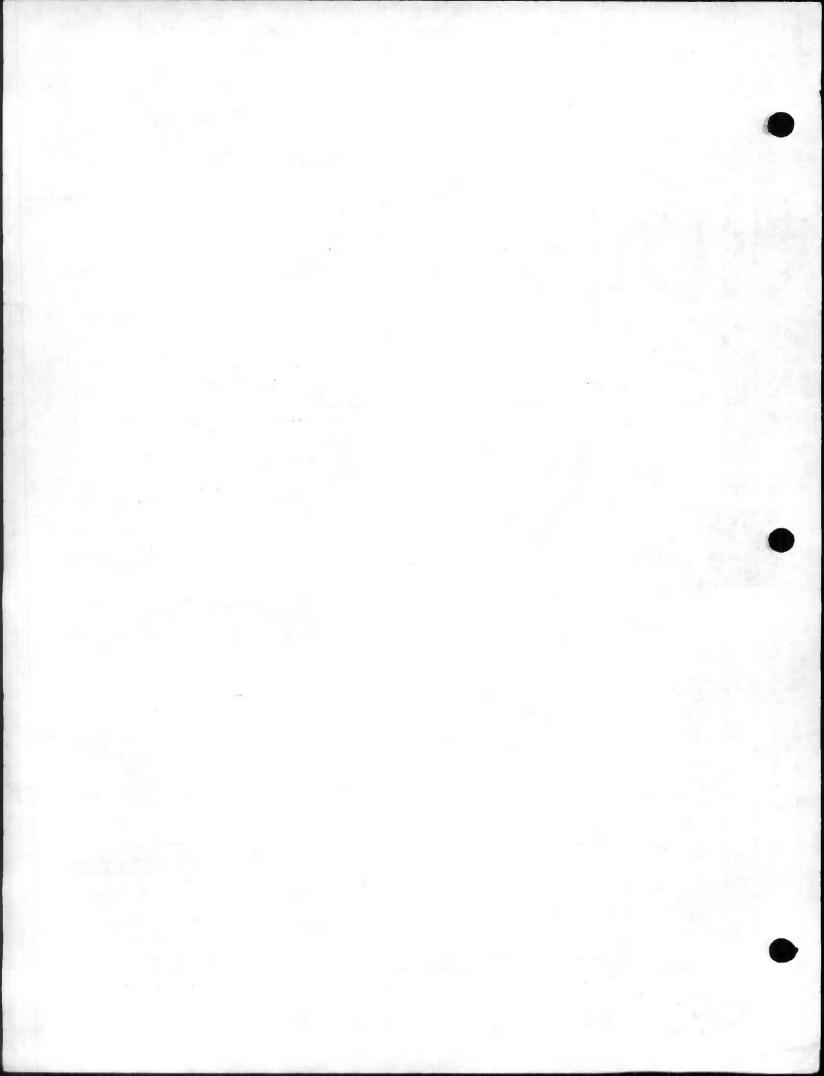
State

Registrar

To the Mospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by tha funerel director;

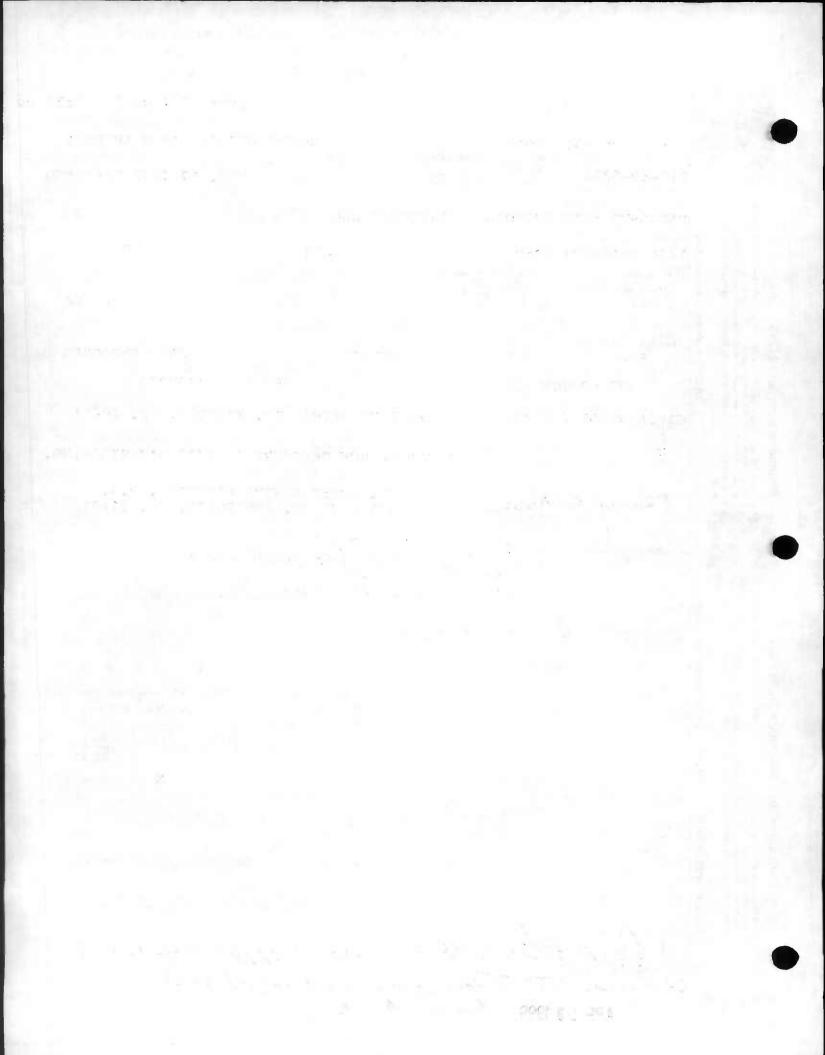
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 4 0 5

					Cer	tificate o	t Death			Reg. No.		
Dhysis	ion	1. Decedent's Name (First, Middle,	Last)						2. Deta of De		Yaar	3. Time of Death
Physic /Med			QUEEN						APRIL	7 Day 999		4:30 pm
Exami	ner	4e Fecility Neme (If not institution,		7)					cation of Deeth	4c. County		MDET
-		1460 ROSSBACK 5. Social Security Number 6		ge (In yrs. las	t birthday)	if Under 1 Yea	r If Undar	24 Hrs.	8. Data of Birt			
Funeral Director	_	219-40-8333	15℃M 2□F	55	Yrs.	Months Day	s Hours	Min.	8. Data of Birt (Month, Da	y, Yeer) 17 194:		placa (Stete or Foreign try) RYLAND
ъ.		Usuel Residenca of Decadent		10.00								Od toolds Obs. Limits
ith the Marylan or 28a-f show	ctor	10a. State 10b. County MARYLAND ANNE	ARUNDEL		IDSOI	VILLE						0d. Insida City Limits 1 Yes 2 □ No
and 2 should be filed within 72 hours after death with the Menyland Health and Mentle Hygiene. The marked other than "netural", or items 23e or 28e-f show other treumetic event, the Medical Exercines must be notified.	al Director	10e. Street end Number 1460 ROSSBACK	ROAD			10f. Zip Code 2 1 (035			10g. Citizen of	Whet Cour	ntry?
items inerms	Funeral	11. Marital Status	12. Wes Decedent Armed Forces	?	13. V	Vas Decedent of Yes, specify Cu	Hispanic Or Iban, Mexical	lgin? (Spe	ecify Yas or No Rican, etc.)		ca - Americ ck, White,	
thin 72 hours after a. an "natural", or it	by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X If Yes, Give Year or Datas:		1	□Yes 2☐N	o Specify:			Specif	y: B	LACK
n 72 hours natural',	Completed	15. Decadent's (Specify only highest			16e. Deced	ent's Usuel Occ kind of work dor OO NOT use reti	upetion e during mos	t of worki	ing	16b. Kind of B	iusiness/în	dustry
within ana. than	mp	Elementary/Secondary (0-12)	College (1-4or	5+)			rea)			SELF	EMPL	OVED
filed with Hygiana. Wher than		6th 17. Fathar's Nama (First, Middla, La	st)	1	F	ARMER	18. Moth	er's Neme	(First, Middle,	Meiden Sumer		OTED
should be filed within nd Manta! Hygiana. marked other than umatic event, the Manta!	To Be	JOE BOSTO	N				P	AULI	NE BR	ADFORD		
and 2 should be file aalth and Mantal Hy n 27 Is marked oth er traumatic event		19e. Informent's Neme/Reletionship CAROL WELLS (S	(Type, Print) SISTER)		19b. Mailin 2242	g Address (Stre	et end Numb	er or Rure	WALDO	ar, City or Town	Stete Zic	601
2 5		20e. Method of Disposition 1XX Burial 2 □ Cremetion 3	Removal from State	cam	etery, crem	sition (Neme of atory or other p	lace)		Dete	20c. Location		
Pagas mant of Hant: If Ite		4 Donetion 5 Other (Spe		WILS	ON C	HURCH	CEMET	ERY	4/12/	99 GAM	RKIL	LS,MD.
permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lic	ensee			Name end Add			морт	UARY,	D A	
. 40244		23a. Pert 1. Enter the disease, or co	Reese									0 1 Approximate
hath certificate be executed a stranding physician and for use as the burial-transit	VMedical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Lest	b. Es.	Due to (or a)	Personal per	TOUS (on	al	echi	làn	1	
	Physician	Pert tl. Other significant conditions	contributing to death	but not resulti	na in the ur	deriving cause	niven in Part	i	23b. Did	tobacco use co	ontribute t	o the cause of death?
that the de ed by the datached	hys	or a significant conditions	Contributing to death	Dut Hot 163ans	ing in the di	identyllig dadae	giveir arr arr			Yes 2X No	3 □ Pro	
law requires that tha as been signed by th	by								24a. Wes	en eutopsy	24b. W	ere eutopsy findings
Physician: Tha law requires the cartificata has been signeral director, paga 2 should be	Completed								pend	ormed?	CC	ompletion of cause deeth?
ysiclen: Tha I s cartificata hi director, paga									10	Yes 2 No	11	☐ Yes 2☐ No
Physician: The this cartificata	Be	25. Was case referred to medical examiner?	Hospital:			[Whor:		h (Check only o			
Phys r this	: To	1 ☐ Yes 2 No 27. Manper of Death	1 ☐ Inpat 28a. Date of Inj		NOutpetien 8b. Time of	28c. In	4 L N	-		denca 6 □Ot how injury occu		fy)
Attending ar daath. ector: Aftal by the funa	ation	Neturel 5 Pending	(Month, D	ay Year)	Injury			No				
or Attending after death. Director: Aftai d in by the funa	Certification:	2 Accident Investigation 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, straet, fectory, offica building, etc. (Specify)							28f. Location (City or To	Straet end Num wn, State)	ber or Rur	al Route Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th complataly filled in by the funeral	edicai C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best arniner: On the basis of and mannar s	of examinetion	edge, deeth n end/or Inv	occurred at the	time, dete ar opinion, de	nd place, a	and due to the ed et the time,	cause(s) end m	enner es s , end due t	steted. o the cause(s)
of the	Me	29b. Signeture and title of cartifier	~ 1	. (1	29c. Lice	nse number			29d. Date sign	ad (Month,	Day, Year)
->-0		▶ Wheat	Della	111-6	1	MD	000	179	761	4-1	2-0	79
		30. Name and address of person with	o completed cause of	deeth (Item 2	3e) (Type, I	Print)	1.64	11	nd. 11	2111		
	210	DR. Far ISIS / (31. Dete filed (Month, Dey, Year)		for C		RUN	10110	10/1	na. Il	117		
St Regist	ate rar	APR 13	1999	- Signatur	1	1,00	the/					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1999 8:25 PM Eleanor Dorothy Richeson 7, April /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 37 Fountain Ridge Circle Parkville If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** Months 1 M 2 M F Days Director 63 April 6, 1936 Maryland 215-34-2358 Usuel Residence of Deceden with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 66 Open Gate Ct. 21236 USA Funeral deeth 14. Rece - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus permit. Pages 1 and 2 should be filled within 72 hours effer to Department of Health and Mentiel Hygiene. Important: If Item 27 is marked and many injury or color. 1 ☐ Never Married 2 TMarried If Yes, Give Yeer or Dates: 1 ☐ Yes 2 ▼ No Specify: White Specify: py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Registered Nurse 3 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Loretta Elizabeth Grimm Myer William Emmel 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 66 Open Gate Ct., Baltimore, MD 21236 Charles M. Richeson / Husband 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State Air Memorial Gardens 4-10-99 Bel Air, Maryland 5 □ Other (Spedi 4 Donation Buneral Service U 21. Signature 22. Name and Address of Facility
Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 not enter the mode of dying, such es cardiac or respiretory errest, or complications that cause II Lin only one cause on each line **Physician** react Corcina /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner physician and s the burial-transit The law requires that the death certificate be axecuted Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events. Records, P.O. Box 68760. Physician/Medical thet Initiated events resulting in death) Last Due to (or as a consequence of): 98 attending | signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 Yes 2 46 3 Probably 4 Unknown p 24b. Were autopsy findings evailable prior to completion of ceuse of death? 24a. Was en eutopsy Completed been: 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital director 25. Was cese referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this furieral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) by 4 Homicide To the Hospital o within 24 hours af To the Funeral DI edicai Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20396 14 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Raven Blud Balto MS Hahr Loch 5601 31. Dete filed (Month, Day, Yeer) State 9 1999 APR Registrar

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State of Maryland / Department of Health and Mental Hygiene

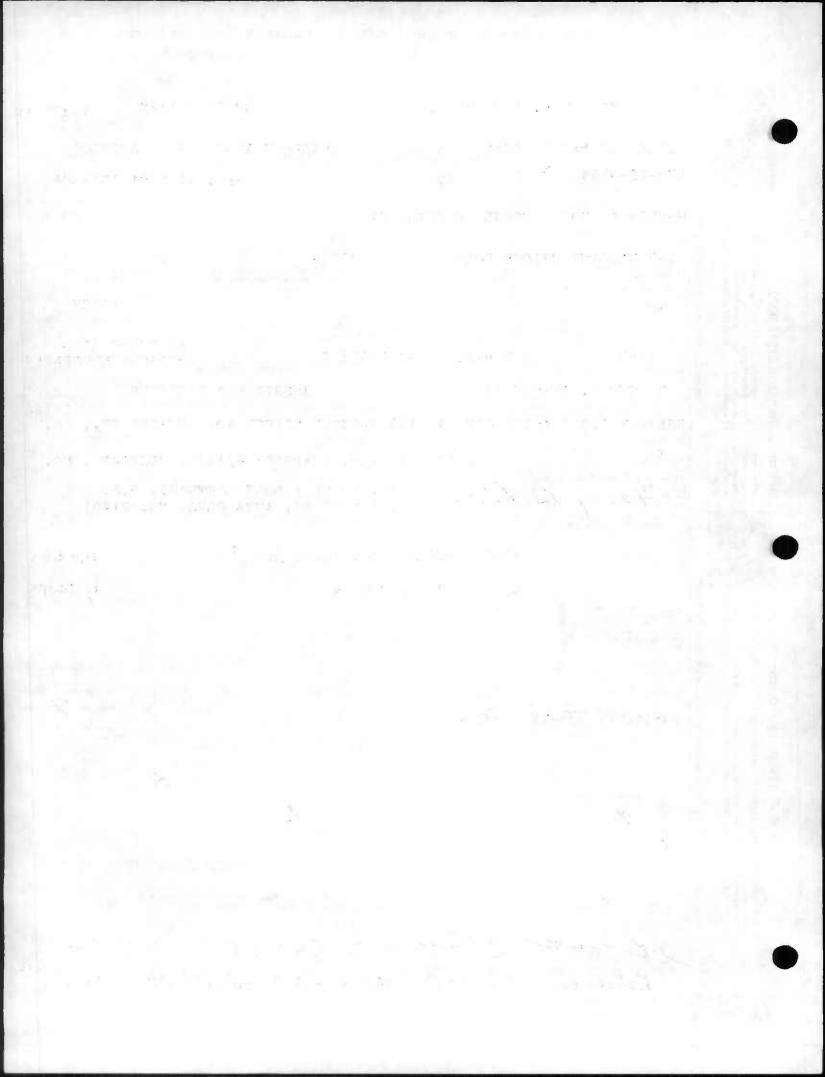
Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 1999 WALTER L. REEVES JR. 9 APRIL 11:00 am /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** If Under 1 Year | Hours | Min. | Month, Day, Yeer) KNOLLWOOD MANOR ELDER CARE Yeer)

ANNE ARUNDEL

9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral X** M 2 □ F Yrs. 578-09-9784 Director 97 SEPT. 11 1901 ALABAMA Usual Residence of Decedent the Merylend 10b. County 10c. City, Town or Location 10d. fnside City Limits 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MARYLAND ANNE ARUNDEL SEVERNA PARK 1 S Yes 2 □ No Director 10a. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 103 MAGOTHY BRIDGE ROAD 21146 US Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Detes: 14. Race - American Indian. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 2 should be filed within 72 hours efter of end Mental Hygiene. is marked other than "natural", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ♥ No Specify: Š 3 ₩ Widowed 4 Divorced BLACK Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) BALTIMORE AFRO 18. Mother's Neme (First, Middle, Maiden Sumame) 12th 2 yrs. JOURNALIST 17. Fether's Name (First, Middle, Last) Be WALTER L. REEVES SR. JESSIE MERRIWEATHER 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21146 19a. informent's Name/Relationship (Type, Print) permit. Peges 1 end 2 sh Department of Heelth end Important: If item 27 is m any injury or other traum SHIRLEY LYONS (CARE GIVER) SEVERNA PK., 103 MAGOTHY BRIDGE RD. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 15€ Burial 2 Cremation 3 Removal from State LINCOLN MEM. CEMETERY 4/15/99 SUITLAND, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility WM. REESE & SONS MORTUARY, P.A. Ham II. Lese 821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part1. Enter the discusse or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, interval Between Onset end Deeth Leese **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) cerebrovascular accident Examiner Examiner physician and the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Box 68760. that the death certificate be Physician/Medical Due to (or as a consequence of): 98 esn Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of deeth? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown à 24b. Were eutopsy findings eveilable prior to completion of cause Completed 24e. Wes en eutopsy pege 2 2 X No 1 ☐ Yes 2 ☐ No certificate director. Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funerel 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident or Attending efter deeth. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours e Hospital Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and eddress of person who completed cause of deeth (item 23e) (Type, Print) Blud Arno MD on 31. Datediled (Month, Dey, Year) 32. Registrer's Signeture 1 3 1999 Registrar APR



State of Maryland / Department of Health and Mental Hygiene

	4 Decedentle Name /First Middle	f mod)				2. Date of Dea	Reg. No.	2.7	ma of Death
Physician	Decedent's Name (First, Middle,					Month	Day	rear	ime of Death
/Medical	ELMER THURMA		SR.		4b. City, Town, or L	April			5:56 Ar
Examiner	4e Facility Name (If not institution, g				40. City, Town, Or E	ocation or Death	4c. County of	Death	
	156 South Queen		. da land bila	hday) If Under 1 Yes	Rising ar If Under 24 Hrs.		Ced		2
Funeral		. Sex 7. Aga 1⊠ M 2□ F	a (In yrs. last birt	Months Day		8. Date of Birth (Month, Day		9. Birthplaca (S Country)	
Director	235-34-8307 Usual Residence of Decedent		73			January	19, 1926	West V	irginia
e k	10a. State 10b. County	000000000000000000000000000000000000000	10c. City, Town	or Location				10d. Ins	ide City Limits
or seho	Ma 1 1	. 1						1 🛭	Yas 2 No
or 28a-f a	Maryland Cec	11	1	Rising Sun			10a. Citizen of Wh	nat Country?	
0 0 0									
r theme 23s direct must.	156 South Queen	12. Was Decedent B	Ever in II S		21911 Hispanic Origin? (Sr	pacify Yes or No-	United	States American Indi	ian
The Ha	1 Never Married 2 Married	Armed Forces?		If Yes, specify Co	f Hispanic Origin? (Sp Joan, Mexican, Puerto	Rican, etc.)	Black,	White, etc.	
by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	US Navv	1 ☐ Yes 2 ☒ N	o Specify:		Specify:	White	1
permit. Feges 1 and 2 should be lied within /2 hours are reach with the marylend Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item 23a or 28a-f ahow any injury or other treumatic event, the Medical Emitries must be notified at once. To Be Completed by Funeral Director	15. Decedent's		WWII	Decedent's Usual Occ	unation		16b. Kind of Busi	iness/Industry	
olet and	(Specify only highest	grade completed)		(Give kind of work dor life. DO NOT use refi	ne during most of work	king		,	
om that	Elementary/Secondary (0-12)	College (1-4or 5		iner			Coal mi	ine	
tal Hygiene. I dother than "natural vent, the Modelled Be Completed	17. Fathar's Nama (First, Middla, La	st)			18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
Mental Me	Charles Thomas	Diddlo			Phoebe	Catheria	ne Yates		
M br	19a. Informant's Name/Relationship		19b.	Mailing Address (Stre	1			tate, Zip Code)	
17 in				South Que					
Hea Hea	Elmer T. Riddle 20a. Method of Disposition	, Jr. / Son	20b. Place of	Disposition (Name of			20c. Location - C		
or of the	1 ☑ Burial 2 ☐ Cremation 3			y, crematory or other p		April 16			
tant Siury	4 Donation 5 Other (Spe		Grandy	iew Memory		1999 I	Bluefield	i, Virg	inia
Deparament in post	21. Signature of Funeral Service Lie	Solation /		22. Name and Add Crouch Fu	neral Home				
70389	(1000 G. 1	was		127 South	Main Stre	et, Nort	h East,	MD 21	901
	23a. Part1. Enter the disease, or co shock, or heart failure. List on	omplications that caused	the death. Do n	ot enter the mode of d	lying, such as cardiac	or respiratory er	rest,	Appro	ximate al Between
hysician				7				Onset	t and Death
/Medical	Immediate Cause (Final disease or condition		ACITO	K MI					
Examiner	resulting in death)	а.	Due to (or as a c	onsequence of):					
on end ial-transit Examiner			CH						
physicien end as the burial-transit edical Examir	Sequentially list conditions,	0.	Due to (or es e c	onsequence of):					
En	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying							1	
physicies the bur	Cause (Disease or Injury that initiated evants resulting in death) Last	c	Dua to (or as a c	onsequence of):				1	
	Toolang in doday Last								
ettending for use a		d							
alch sich	Part II. Other significant conditions	contributing to death bu	ıt not resulting in	the underlying cause	given in Part I.	23b. Did t	obacco use cont	ribute to the ca	ause of deat
d by the ettending leteched for use a Physician/M	-ARKUMAI AL	will done	104/11	1		10	Yes 2□No	3 Probably	4 Kunkno
igned be de	- MURINIAC NO	KIIC AUG	10/2/10/						
ins low requires the that death central ate has been signed by the ettending page 2 should be deteched for use Completed by Physician/M	- ARTHRITIS	6	erakon	IL VASCO	MAR K	24a. Was	an autopsy med?	24b. Were aut available	opsy findings
cate has been si , page 2 should	1119/11/11/	- 10	MICHON	C VAJOU	CAN DO	pario	illied?		on of cause
certificate has rector, page 2	- 44 home in	11 - 80	20SOM	14		101	res 2 No	1 🗆 Yes	2010
or, Pu	25. Was case referred to medical	i coe	0301.7		26. Place of Dea			1 100	2×110
or death. by the funeral director, iffication: To Be (examiner?	Hospitat:	a a D E B/O	nation 20 DOA	Whor	. 1		(Canaiba)	
rthis coral direction.	27. Manner of Death	1 Inpatie			4 ☐ Nursing H	-	dence 6 Other		
Afte fune	1 Accident 5 Pending investigat	(Month, Day	Year) In	jury V	ronk? ☐ Yes 2 ☐ No				
deal ctor: y the	3 Suicide 6 Could not	be Ose Bless of Isia	inv - At home far	m, street, factory, offic		28f Location /5	Street and Number	r or Rural Route	a Number
is after death. el Director: After to led in by the funera Certification:	4 Homicide determine	building, etc		m, stroot, motory, one		City or Tow			
within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier Certifying	Physician: To the heat a	d my knowledge	death occurred at the	time date and size	and due to the	nauga/e) and man	nor se cintari	
n 24 hours		Physician: To the best of aminer: On the basis of	axamination and	Vor investigation, in m	y opinion, death occur	red et the time,	date and place, ar	nd due to the ca	ause(s)
Med mple	29b. Signatura and title of configu	and manner sta	teO.	20n Line	ense number		29d Date signed	(Month /Sev Y	(aur)
	255. Signatura and this of committee	2/2 11	1	250. Lick	117001	7	///	11/1/2	1017
+1VA	1/100	I'm Mu		1)	90000		7/1	1/27	
4111	30. Name and address of person wh	o completed cause of de	eath (Item 23a) (Type, Print)	2011 11	1/ -	171		
	31. Date filed (Month, Day, Year)	219 2.	UNION	MVE. 14	no, Me	1, d/C	18		
		32. Registra	r's Signature						

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State of Maryland / Department of Health and Mental Hygiene

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ician											Reg. No.		
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dical	4a Facility Nama (If not institut						4	b. City, To	wn, or Lo	ocation of Deat			
niner	Frederick Hea							Fred	eric	k		deri	
	5. Social Sacurity Number			Aga (In yrs. las	t hirthday)	If Undar	1 Yaar	If Undar		8. Data of Bir			
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90	10e. Street and Number	hing	COII	D	OUISL	10f. Zlp	Code				10g. Citizan of	What Co	untov?
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	19a. Informant's Name/Ralation										er, City or Town		
	Susan Steelma	ın (D	aughter)	2826	Park	Mil.	ls Ro	ad,	Adamst	own, MD	2171	.0
	20a. Mathod of Disposition			20b. Plac	ca of Dispo	sition (Nen	na of			Data	20c. Location	- City or	Town, Stata
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-	21. Signature of Funeral Service	_		J.						720755	DILLCHS	Jul 5	Tidly Land
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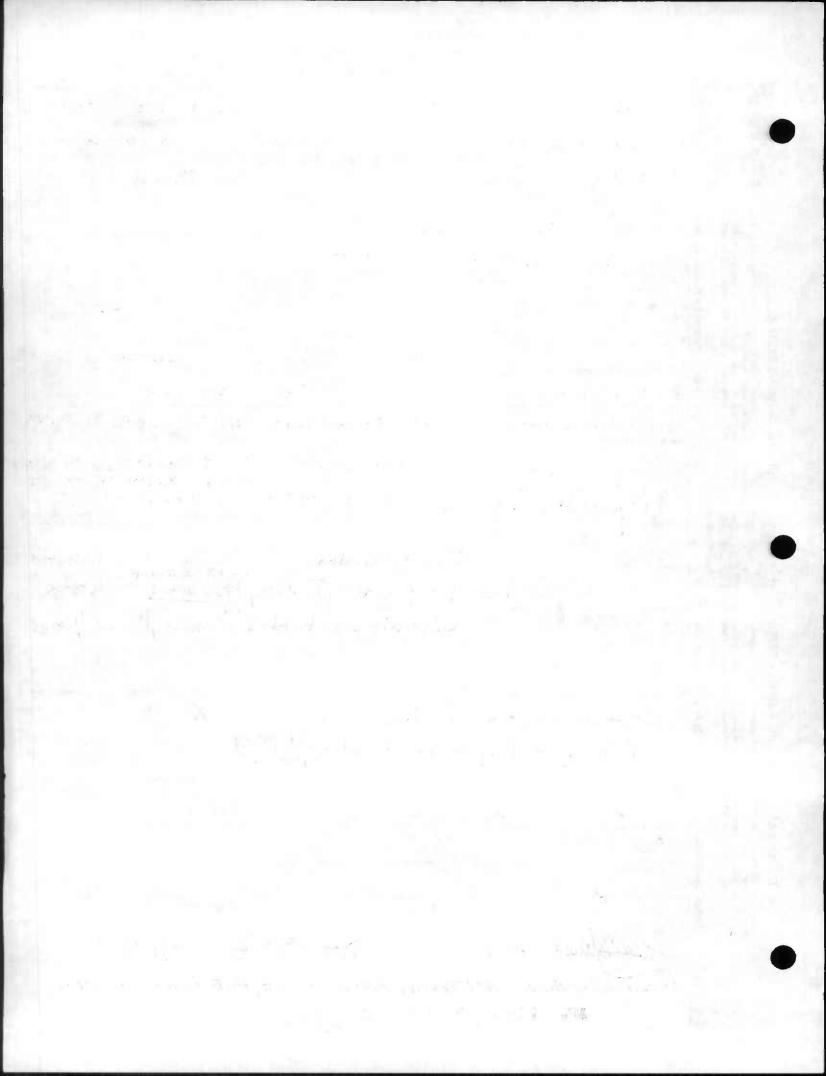
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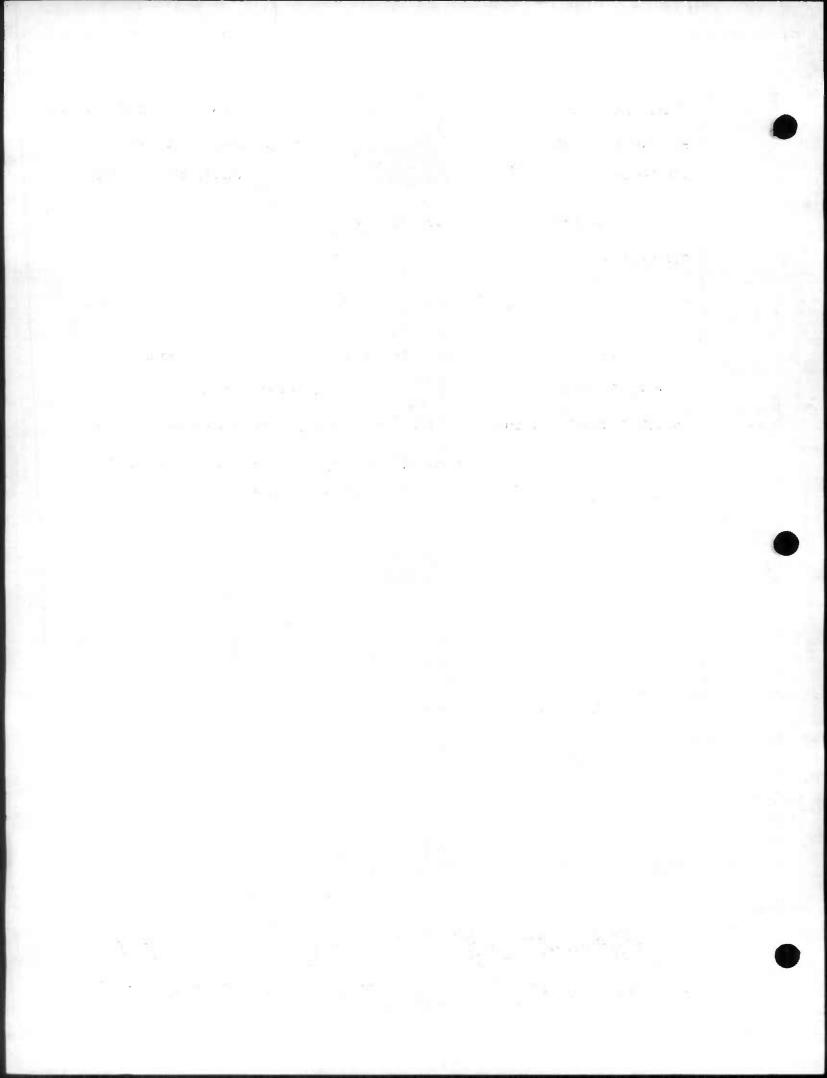
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vith the Me or 28e-1 s	Maryland Frederic	ck Fr	rederick	10f. Zip Code			10g. Citizen of What	Country?
N With	6947 Hatfield Cour	rt Apt 107		21703			USA	
within 72 hours efter death with the Meryland ene. than 'natural', or items 23s or 28s-1 show as Medical Evantuer must be notified at ampleted by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 20 No If Yes, Give				(Specify Yes or No erto Rican, etc.)	14. Race - A Bleck, W Specify:	
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s 1 and 2 should be filed within 72 ho if Health and Mentel Hygiene. Item 27 is marked other than "nature other traumatic event, the Medical To Be Completed	(Specify only highest green Elementery/Secondary (0-12)	College (1-4or 5+)	(Give ki	nd of work done NOT use retire	during most of w	rorking		
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2 should be filed and Mentel Hygi is marked other aumatic event, To Be Co	Norman E. Bryson				Trene	Mildred	Vincent	
should Ind Men	19a. Informent's Name/Reletionship (7	Type, Print)	19b. Mailing	Address (Street			er, City or Town, Stet	e, Zip Code)
1 and 2 s Health ar Pm 27 is ther trau	Richard Stoehr, hu	isband	6974 H	atfield	Court,	Apt 107,	Frederick	c, MD 21703
ges 1 and t of Haalth if Item 27 or other t	20a. Method of Disposition	201	o. Plece of Disposition cametery, crema	tion (Name of	nce)	Date	20c. Location - City	or Town, State
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permit. Par Departman Important: any injury once.	21. Signature of Filneral Service Licen	see	22.1	Name and Addre	ess of Facility I	Keeney an		Funeral Home
Physician	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused the d		the mode of dyi	ing, such es card	ac or respiretory e	rrest,	Approximete tntervel Between Onset end Deeth
/Medical Examiner	Immediete Ceuse (Finel disease or condition resulting In death)	e. Due to	o (or es e consegue	equalic		10 Page	Languas	Minutes
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ceta be axecu physician and the buriel-trea	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury	c	hvoni	c 0 65	structi	ue Fully	may DEC	no Years
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certificate hes rector, page 2 Be Comp	J				1	10	Yes 200	1 ☐ Yes 2 ☐ No
	25. Was case referred to medical				26. Plece of D	eath (Check only	one)	
Z S D	examiner? 1 ☐ Yes 2 No	Hospitel: Lippatient 2	□ ER/Outpetient	3□ DOA Ot	her-		idence 6 Other (S	Specify)
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tal or Attending Prs after death. al Director: After tied in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pleca of injury - A building, etc. (Spe	t home, farm, stree	et, factory, office			(Street end Number or wn, Stete)	r Rural Route Number,
Hospi 4 hour Funer tely fill		vaicien: To the best of my liner: On the besis of examend menner stated.						
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	30. Name and address of person who o	completed cause of deeth (I	tem 23e) (Type, Pr	rint)	100		11101	
	30. Name and address of person who of WILLIAMH. JUHN	completed cause of deeth (I	tem 23e) (Type, Pr	int)	DRIVE	FREDE	Eleicteme	21702



State of Maryland / Department of Health and Mental Hygiene

And Mantal Hyglene. It marked other than 'natural', or items 23a or 23a-f show the Mantal and the Landscape and Lands	by Funeral Director	Pearl Thelma Smy 4e. Fecility Neme (If not institution, give 931 Quarry Road 5. Social Security Number 220-24-2262 Usual Residence of Decedent 10a. Stete 10b. County MD Harford 10e. Street end Number 931 Quarry Road 11. Marital Stetus 1 Never Merried 2 XMarried 3 Widowed 4 Divorced	e street and number) PX TAGE	Yrs.	If Under 1 Yee Months Dey		Grace 8. Dete of B	Harfor	rd	3:20pm	
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A TOURS BLOW THE STATE OF THE S	his cardificate has been signed by the attending physician and a constraint if them constraints of constraints	To the Funeral Director: After this cardificate has been signed by the attending physician and complately filled in by the funeral director, page 2 should be detached for use as the bunial-transit and post any Injury or other any Injury or other when the post any Injury or other any In	20e. Method of Disposition 1	20e. Method of Disposition 10	20e. Method of Disposition 20b. Place 20c. Method of Disposition 1	20e. Melhod of Disposition 1	20e. Melhod of Disposition 1 XBuriel 2 Cremation 3 Removel from Stete 4 Donotion 5 Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Add Mitchell-Signeture of Funeral Service Licensee 23a. Fault. Enter the disease, or complications that caused the deeth. Do not enter the mode of disease or condition resulting in deeth) 23a. Fault. Enter the disease, or complications that caused the deeth. Do not enter the mode of disease or condition resulting in deeth) 25a. Fault. Enter the disease, or complications that caused the deeth. Do not enter the mode of disease or condition resulting in deeth) 25a. Fault. Enter the disease, or complications that caused the deeth. Do not enter the mode of disease or condition resulting in deeth) 25a. Fault. Enter the disease, or complications that caused the deeth. Do not enter the mode of disease or conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhieted events resulting in deeth) 25a. Fault. Enter the disease, or complications that caused the deeth. Do not enter the mode of disease or conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhieted events resulting in deeth) 25a. Fault. Enter the disease, or complications that caused the deeth. Do not enter the mode of disease or conditions, if any, leading to measure of the disease or conditions, if any, leading to measure of the disease or conditions, if any, leading to measure of the disease or conditions and the deeth. Do not enter the mode of disease or conditions, if any, leading to measure of the disease or conditions, if any, leading to deeth. Do not enter the mode of disease or conditions, if any, leading to measure of the disease or conditions, if any, leading to deeth. Do not enter the mode of disease or conditions, if any, leading to measure of the disease or conditions, if any, leading to measure of the disease or conditions, if any, leading to deeth. Do not enter the mode of disease or conditions, if any, l	20. Method of Disposition 20. Place of Disposition (Name of Semetery, cremetory or other place) 20. Place of Disposition (Name of Semetery, cremetory or other place) 21. Signeture of Funeral Service Licensee 22. Neme end Address of Feolity 21. Signeture of Funeral Service Licensee 22. Neme end Address of Feolity 23. S. Washington, 24. Neme end Address of Feolity 25. Washington, 25. Washington, 25. Washington, 25. Washington, 25. Washington, 26. Place of Disposition (Name of Semetery, cremetory or other place) 24. Neme end Address of Feolity Mitchell-Smith Fune 12.3 S. Washington, 23. S. Washington, 24. Washington, 25. Washington, 26. Place of Deep 26. Place of	20e. Method of Disposition 10 Supris 20e. Method of Disposition 20e. Method of Di	Solution Solution	Solution Commence Commence



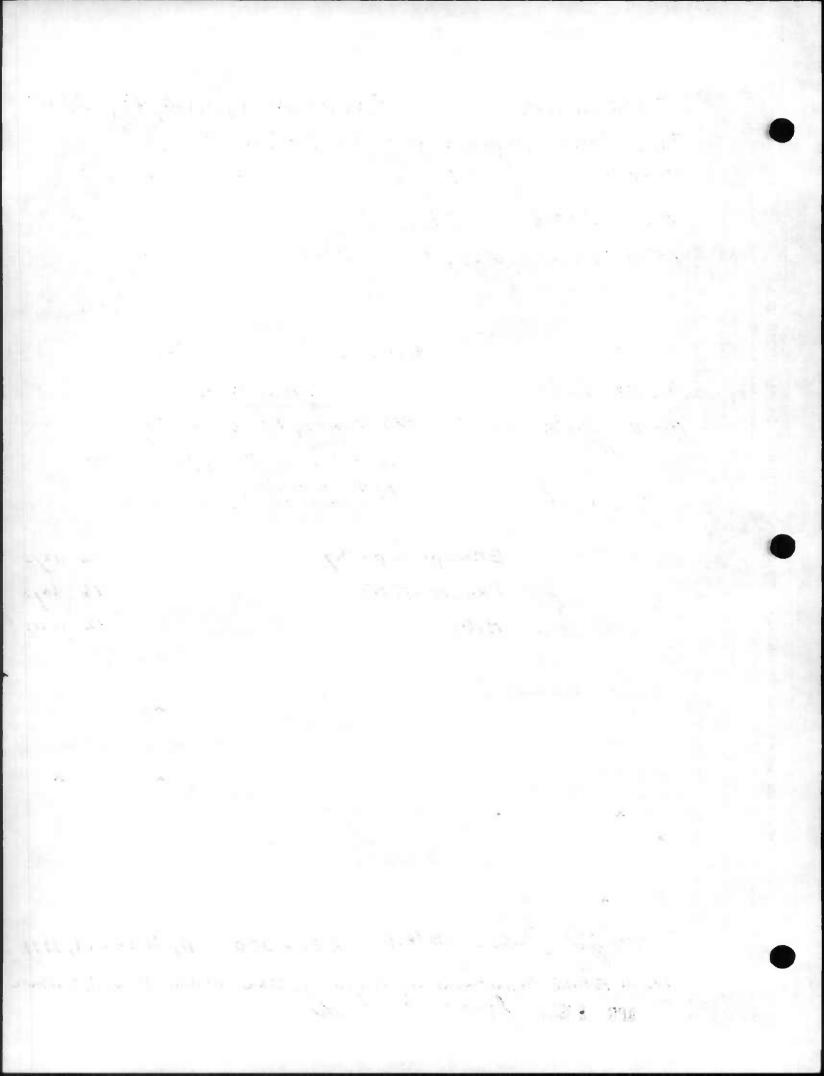


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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month DOLORES EDITH SHAVER April 3, 1999 0635 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1□ M 25 F Hours Yrs. 74 079-18-7428 Aug. 18, 1924 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 3 ☐ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1404 Shirley Drive 21015 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yas 2 ☒ No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Government Clerk 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Joseph Ralph Watts Florence Antoinette Pearson 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Shaver / Daughter 51 Homehurst Lane, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20s. Method of Disposition 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 4-5-99 | Aldino, Maryland ature of Funeral Service Licensee 22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. omas 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Between Onset and Death Immediate Cause (Final PULMANARY INSUFFICIENCY disease or condition resulting in death) Due to (or as a consequence of): ATELECTASIS MUCOUS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CLOSURE OF COLOSTOMY Due to (or as e consequence of): 10ST - OP ANASTOMOTIC LEAK Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tyes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Hospitaf: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No

Physician /Medical

Physician

/Medical

Examiner

Funeral

Director

Nerra 23a or 28a-f show that must be notified at

"naturel", or

permit. Peges 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if tem 27 is marked other than "natually injury or other treumatis avera."

Directo

by

Completed

Be

the Meryland

72 hours efter

Baltimore, Maryland 21215-0020

3

hAVER Dulores

Examiner Physician/Medical Š Completed 8

physician and a the buriel-transit 007 Medical Certification: To

certificate

ald:

deeth.

Hospital or Att
 24 hours effer d
 Funeral Direct

To the Hosp within 24 hor To the Fune completely fi 10

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

AMELITO CANUS, M-D, 31. Date filed (Month, Day Year) State Registrar

27. Manner of Death 1 Di Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending

6 ☐ Could not be

5 1999^{2. Registre's Signeture}

28a. Date of Injury (Month, Day Year)

1 Certifying Physician: To the best of my knowledge death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, data and place, and due to the cause (s) and manner stated.

28c. Injury at Work?

29c. Licanse number

1 Tyes 2 No

28d. Describe how injury occurred

in, in my opinion, death occurred at tha time, data and place, and dua to the cause(s)

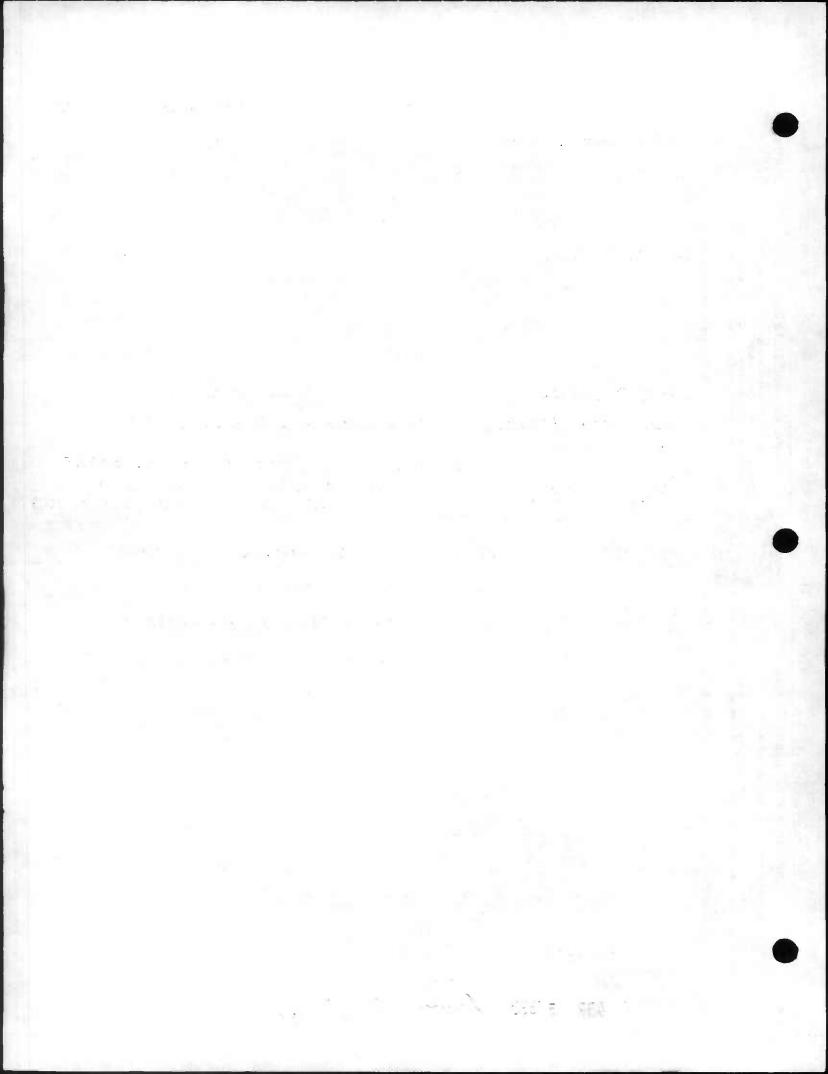
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d, Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

28b. Tima of

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene

THOMAS	F.	SMITH	SR.

TIME TO THE CHILLIII OIL.	THOMAS	F.	SMITH	SR.
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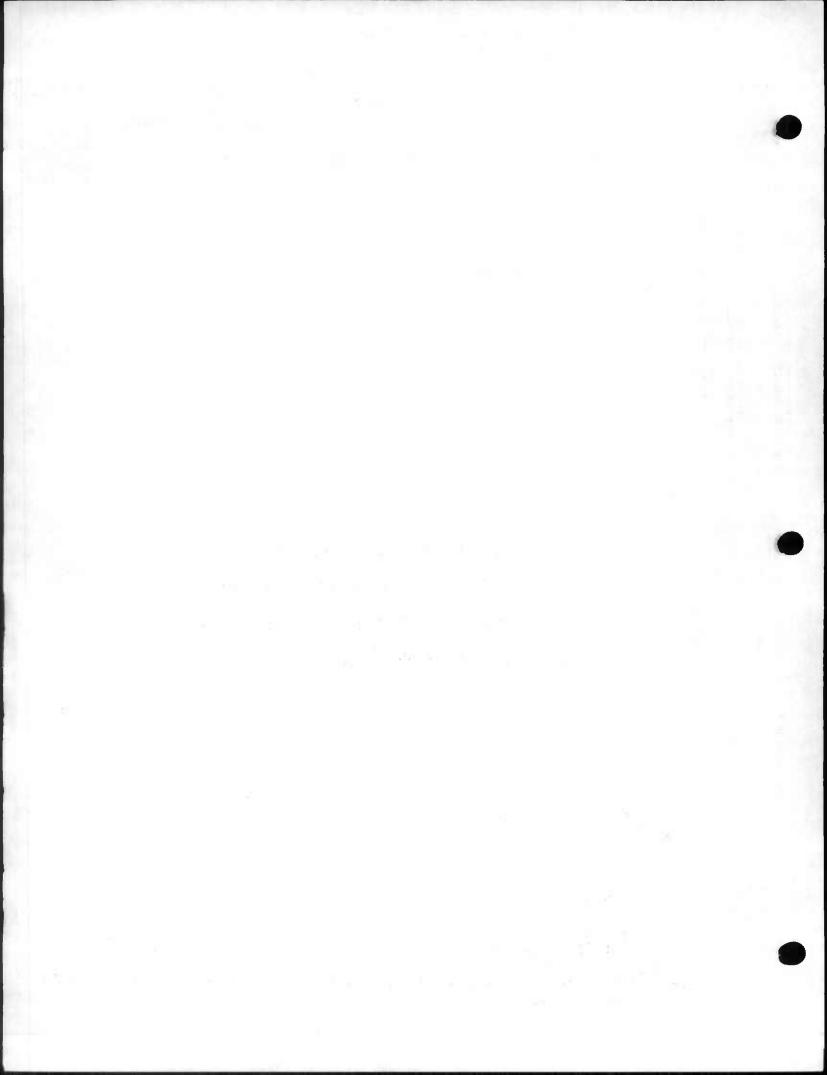
IIIOMAS I.	SMITH SR.		Certificate o	f Death	Re	ng. No.				
	1. Decedent's Name (First, Middle, La	st)		-	2. Date of Deat	_		3. Time of Death		
Physician /Medical	THOMAS F. SM	ITH SR.			APRIL	8, 199	Year 19	1550 PM		
Examiner	4a Facility Name (If not institution, giv UNIVERSITY HOSPI	e street and number)		4b. City, Town, or L BALTIMO		4c. County of NON				
Funeral Director	5. Social Security Number 6.5 218-26-0944	7. Age (In yrs	Yrs. If Under 1 Ye Months De		8. Date of Birth (Month, Day, MARCH 2	Year)		ce (Stete or Foreign y)		
deeth with the Maryland res 23e or 23e-f show Linust be notified at	Usual Residence of Decedent 10a. State 10b. County MARYLAND ANNE A		ity, Town or Location					d. Inside City Limits		
or 28s-f	10e. Street and Number		10f. Zip Code	•	10	0g. Citizen of W	hat Country	y?		
238 o and	817 B BETSY CO	JRT	214	01		U	IS			
- in and 12	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 ⊠Yes 2 □ No If Hes, Give Year or Detes: 1 9 5 2	If Yes, specify C	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				No- 14. Race - American Indien, Black, White, etc. Specify: BLACK		
I Z1Z15-00Z0 ed within 72 hours at yokens. ner then "neturel", or it, the Medical Exem Completed by It	15. Decedent's En (Specify only highest grant Elementary/Secondary (0-12)	lucation	16a. Decedent's Usuel Occ (Give kind of work do life. DO NOT use ret	ne during most of wor	king	16b. Kind of Bus	siness/Indu	stry		
Con Con	6 th 17. Father's Name (First, Middle, Last,	0	LABORER			SELF F		YED		
Maryland 42 should be flie th and Mental Hy 7 is marked other treumatic event To Be C	17. Father's Name (First, Middle, Last, JOSEPH SMITH				ne (First, Middle, M	Maiden Sumame)			
T MAN A	19a. Informant's Name/Reletionship (Type, Print)	19b. Meiling Address (Stre	SARAH et end Number or Ru		City or Town, S	State, Zio C	Code)		
M	MARY FOOTE (DA		4 ALDER RD							
Baltimore, armit. Pages 1 a Separtment of He mportant: If Nem ny injury or othe nose.	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific	Removel from State	Plece of Disposition (Name of cemetery, cremetory or other p	place)	Date	20c. Location - C	City or Town	n, State		
Baitt parmit. Departm importa any inju	21. Signature of Funeral Service Licer Harry 23a. Part1. Enter the disease, or com	. Leese		SE & SON	S MORTU	ARY, P	.A.			
requires that the death certificate been signed by the attanding physician/Medicate the barrier of the standing physician/Medicate the standing physician/Medicate the standing physician/Medicate the standing physician in the standing physician physician in the standing physician physician physician phys	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	bDue to ((or es e consequence of):	1 1						
	Part II. Other eignificant conditions o	Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.					23b. Did tobacco use contribute to the cause of 1 Yes 2 No 3 Probably 4 Z			
					24a. Was a perform		avail	e autopsy findings lable prior to pletion of cause eath?		
2 4 6					1 / Ye	s 2 No	1/6	Yes 2□ No		
VITBILITY Idelan: The certificate irector, per	25. Was case referred to medical examiner?			26. Place of Dae	th (Check only on	9)				
Physician: Trihis cartificat rral director, pr	X⊠ Yes 2□ No	Hospital: 1 Inpatient 2X	XER/Outpatient 3 DOA 28c. Ir		ome 5 Reside		, , ,,			
ding I	27. Manner of Death 1 Netural 5 Pending 2 Accident investigation	28d. Describe how injury occurred Subsect Show h								
To the Hospital or Attending Phywithin 24 hours shard seath. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 7	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (3 - 20)					28f. Location (Street and Number of Hural Route Number, City or Town, State) 70				
To the Hospital within 24 hours of To the Funeral completely filled	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) end manner es steled. (Check only one) Check only one) Check only one)									
To the within To the complete	29b. Signature and title of certifier	U. Fig.	10	onse number 0.C.M.E	2	9d. Date signed APRIL		ay, Year) 1999		
	30. Name and address of person who	-	m 23a) (Type, Print) 111 Penn Stree	t, Baltim	ore, Mary	land 21	201			
State Registrar	31. Date filed (Month, Day, Year) APR 13	32 Registrar's Sign	ature / /	als						

State of Maryland / Department of Health and Mental Hygiene

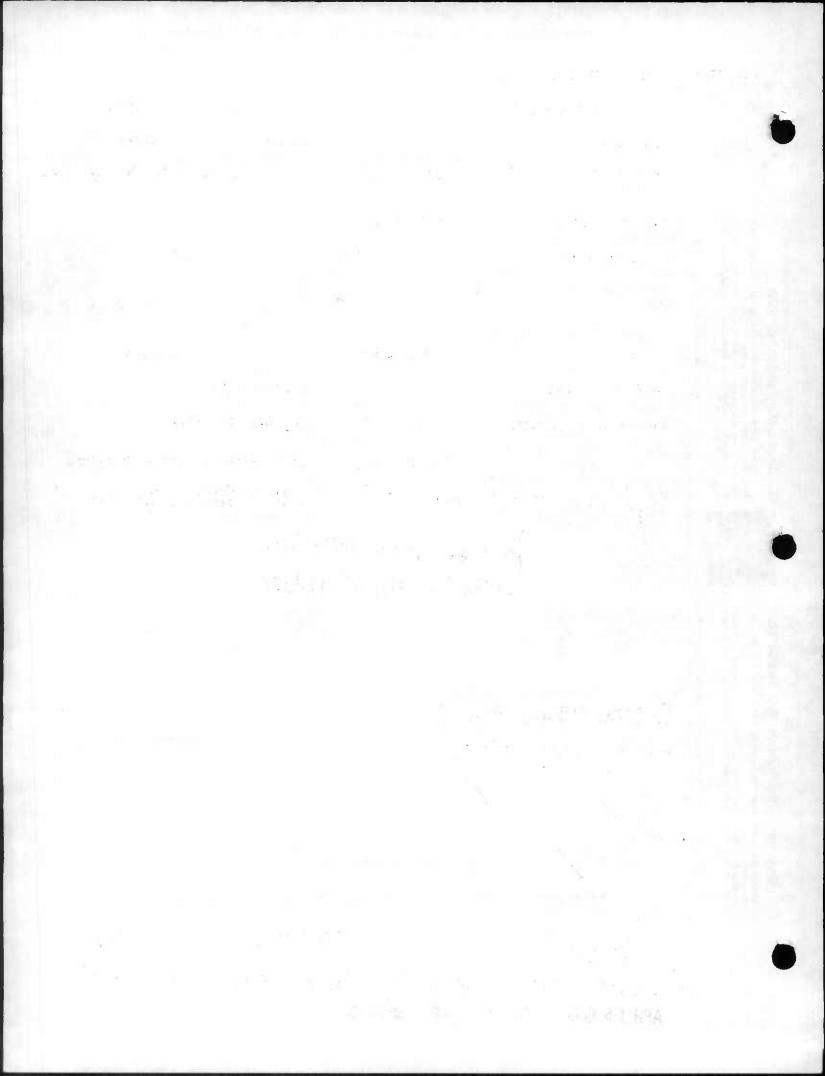
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Veal **Physician** PRANAS SIMANAVICHUS 2340 04 1999 06 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital BETHESDA MONTGOMERY 5 Social Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day Year) 03/18/1921 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** 1♥M 2□F Deys 577 58 7249 78 Lithuania Yrs. Director Usuel Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Madical Examiner must be notified at MD Prince George's Lanham 1 ☐ Yes 2 No Director 10e. Street end Number 10f, Zip Code 10g. Citizen of Whet Country? deeth with 9322 Wyatt Drive 20706 USA items 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ê No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☐ No Specify: 14. Race - American Indian, Black, White, etc. should be filed within 72 hours effer on Mental Hygiene.

marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0020 White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contractor Home Restoration permit. Pages 1 and 2 should be filled.
Department of Health and Mental Hygis important: If Item 27 is marked any influry or other. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) KAZYS SIMANAVICIUS MARIONA GEIGELAITE 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ALDONA SIMANAVICHUS (wife) 9322 Wyatt Drive, Lanham MD 20706 20b. Placa of Disposition (Name of cemetery, cremetery or other place)
Metropolitan Crematory 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from State 4/9/1999 Alexandria VA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name end Address of Fecility Advent Funeral & Cremation Services Falls Church VA 22046 23a. Pert1. Enter the disease, or complications that caused the weath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final RESPIRATORY FAILURE disease or condition resulting in deeth) Examiner SEVELE OBSTRUCTIVE LUNG DISEASE Examiner physician and the buriel-transit The lew requires that the death certificete be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequenca of): PROGRESSIVE MASSIVE FIBROSIS Box 68760, Physician/Medicai NEUMOCONIOSIC ettending p P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the should be deteched 23b. Did tobacco use contribute to the cause of death? 1 Tyss 2 No 3 Probably 4 DrUnknown Records, Be Completed by 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of death? page 2 1 Yes 2 No this certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifical elelely filled in by the funeral director. p. 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 ☑ Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 27. Menner of Deet 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide edical To the Hospi within 24 hou To the Funer completely fil 29a, Certifier 1 Certifying Phyelclen: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end manner es stated. (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. 29b. Signature entititie of certiles 29c. License number 29d. Dete signed (Month, Dey, Year) 126571 of person who completed cause of death (Item 23e) (Type, Print)

MIZUS, MD 4930 DELRAY AVE, BETHESDA, MD 208/4 32. Registrer's Signeture State Registrar



			18-99 WR.		Cer	tificate of	Death	l o Data a	Reg. No.	107	Cime of Death
cian lical	1. Decedent's Name Marian Fe	ehr Slau	ybaugh					2. Date o	Day 15	1999 C	Firme of Death
iner	4a Facility Name (If		give street and nu	m <i>ber)</i>			4b. City, Town Elkto	n, or Location of D		y of Deeth	
	Union Ho		Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24		Birth , Dey, Year)		State or Foreign
	183-05-6		1□M 21 F		7 Yrs.	Months Deys	Hours	Min. May 2	2, 1917	Pennsyl	vania
	Usual Residence of			100 00	h. Taun arla	Ni				10d to	alda Cib. Limita
by Funeral Director	10a. State	10b. County			ty, Town or Lo						side City Limits ☐ Yes 2 ☐ No
	Maryland	Cecil		K	lising	1			10a Citizen of	Whet Country?	
10e. Street end Number 1/2 Louise Court 1/2 Louise Court 21911							USA	Whot County !			
ŀ	11. Marital Status	se cour	12. Wes Dec	edent Ever in U	,S. 13. V	Vas Decedent of I	lispanic Origi	in? (Specify Yes o	r No- 14. Ra	ce - American Inc	dien,
	1 ☐ Never Marrie		Armed Ford 1 Yes If Yes, Gir Year or D	2. No ve		Yes, specify Cub	Specify:	Puerto Rican, etc.	Speci	ack, White, etc.	
ŀ	/0	15. Decedent's	Education		16a. Deced	lent's Usual Occup	oation	of working	16b. Kind of I	Business/Industry	
ŀ	Elementery/Secon		grade completed) College (1-4or 5+)		kind of work done OO NOT use retire	d)	or working			
	12				Homem	aker		La Administração de Articologica de Articologi	Own t		
	17. Father's Name (ddle, Maiden Surna 0 o	me)	
	Harrison 19a. Informant's Na				10h Mailin	a Address /Street	1	abeth Py	umber, City or Town	State Zin Code	<u> </u>
	Charles			И				Sun, MD		, orate, Lip cooc	,
	20a. Method of Disp	osition		20b. F	Place of Dispo	sition (Name of natory or other pla		Date		- City or Town, S	itate
l	1 🛱 Burial 2 🛭 4 🗆 Donation		☐Removal from cify)	State				u 4-18-9	9 Colora,	Marula	nd
	21. Signeture of Full			7 1.	22	. Name end Addre	ss of Facility				
	1	1.0	90	mile	R	T. Foa	rd Fun	eral Hom	e, P. A. g Sun, MI	21011	
_	23a. Part 1. Enter the	ne disease, or co	omplications that of	caused the deat	th. Do not ent	er the mode of dyi	ng, such es ca	ardiac or respireto	bry arrest,	Appr	roximete val Between
Jer	Immediate Cause (I disease or condition resulting in death)	Final	a full	8 Myo	NEWD R	Vmn	mulion	200			
	Sequentially list con if eny, leading to im cause. Enter Under Cause (Disease or i that initiated events		ь с	Due to (c	or as a consequence as a consequence	uence of):	Friur	N V			
	Sequentially list con if eny, leading to im cause. Enter Under Cause (Disease or i that initiated events resulting in death) L Part II. Other significations and the control of the control of the control of the control of the cause of the	ast	b b d d s contributing to do	Due to (c	or es e consed	uence of):	WWY	23b.	Did tobacco use c		. /
	resulting in death) L	ast	b. CS c. d. s contributing to d	Due to (c	or es e consed	uence of):	MUY ven in Part i.	24a.		3 Probably 24b. Were eu available complet	Unknow utopsy findings e pnor to ion of cause
	resulting in death) L	ast	b. CS c. d. scontributing to d	Due to (c	or es e consed	uence of):	WWW.	24a.	1 Yes 2 No Wes en eutopsy performed?	3 ☐ Probably 24b. Were eu available	Unknown utopsy findings e prior to ion of cause
	Part II. Other significations of the control of the	cant conditions W WW	b. CS c. d. scontributing to d	Due to (c	or es e consed	uence of):		24a.	1 Yes 2 No	3 Probably 24b. Were et available complet of death	Unknown utopsy findings e prior to ion of cause
	Part II. Other significations of the control of the	cant conditions W W W W W W W W W W W W W W W W W W W	why of	Due to (c	or es e consed	uence of): uenca of): aderlying cause given	26. Place (24a.	1 Yes 2 No	3 Probably 24b. Were exavailable complet of death	Unknown utopsy findings e prior to ion of cause
	Part II. Other significations of Death 27. Manner of Death	cant conditions W WWW	Hospital: 100 28a. Dete	Due to (c	or as a consequence of the conse	uence of): uenca of): uenca of): uenca of):	26. Place (her: 4 □ Nurs	24a.	1 ☐ Yes 2 ☐ No Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No unity one)	3 Probably 24b. Were et available complet of death 1 Yes	Unknown utopsy findings e prior to ion of cause
	Part II. Other significations of the second	cant conditions W W W W W W W W W W W W W W W W W W W	Hospital: 128a. Dete (Month to be 28e. Plece	Due to (co	or as a consequence of a con	uence of): uenca of): uenca of): deflying cause given the c	26. Place (her: 4 □ Nurs	of Death (Check of Sing Home 5 28d. Describe 28f. Location	1 ☐ Yes 2 ☐ No Wes en eutopsy performed? 1 ☐ Yes 2 ☑ No unity one) Residence 6 ☐ O	3 Probably 24b. Were et available complet of death 1 Yes	Unknow utopsy findings e prior to ion of cause ?
more and in the more and in th	Part II. Other signification of the control of the	cant conditions Cant conditions	Hospital: 128a. Dete (Mon to be build) Physician: To the	Due to (c Due to (c Due to (c) Path but not res Inpatient 2 of Injury of Injury - At hing, etc. (Special	or as a consequence of a conse	uence of): uenca of): uenca of): t 3 DOA Ott 28c. Inju Wo M 1 Deet, factory, office	26. Place of her: 4 \(\sum \) Nurs ry at rk? Yes 2 \(\sum \) N	of Death (Check of Sing Home 5 1 28d. Describe 28f. Locat City of I place, end due to	1 Yes 2 No Wes en eutopsy performed? 1 Yes 2 No nify one) Residence 6 O ribe how injury occion (Street and Nun r Town, State)	3 Probably 24b. Were et available complet of death 1 Yes ther (Specify) urred	Unknown utopsy findings e pnor to ion of cause ? 2000 No
	Part II. Other signification of the control of the	cant conditions Cant conditions	Hospital: 28a. Dete (Mon be be 28e. Plece build) Physician: To the aminer: On the b	Due to (c Due to (c Due to (c) Path but not res Inpatient 2 of Injury of Injury - At hing, etc. (Special	or as a consequence of a conse	uence of): uenca of): t 3 DOA Ott 28c. Inju Wo M 1 eet, factory, office	26. Place of her: 4 Nursing at rk? 1 Yes 2 Nume, date and opinion, death	of Death (Check of Sing Home 5 1 28d. Describe 28f. Locat City of I place, end due to	Now Person of the Cause (s) and place	3 Probably 24b. Were et available complet of death 1 Yes ther (Specify) urred manner es stated.	Unknown utopsy findings e prior to ion of cause ? 2XXNo
to be completed by rhysicial/medical	Part II. Other signification of the control of the	cant conditions Cant conditions	Hospital: 28a. Dete (Mon be be 28e. Plece build) Physician: To the aminer: On the b	Due to (c Due to (c Due to (c) Pue to (c) Due to (c) Pue to (or as a consequence of a conse	uence of): uenca of): uenca of): t 3 DOA Ott 28c. Inju Wo M 1 Deet, factory, office	26. Place of her: 4 Nursing at rk? 1 Yes 2 Nume, date and opinion, death	of Death (Check of Sing Home 5 1 28d. Describe 28f. Locat City of I place, end due to	1 Yes 2 No Wes en eutopsy performed? 1 Yes 2 No nify one) Residence 6 O ribe how injury occion (Street and Nun r Town, State)	3 Probably 24b. Were et available complet of death 1 Yes ther (Specify) urred manner es stated.	Unknown utopsy findings e prior to ion of cause ? 2XXNo
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other signification of the control of the	cant conditions medical properties properties medical conditions medical conditions conditions medical conditions medical conditions medical conditions conditi	Hospital: 28a. Dete (Mon be be 28e. Plece build) Physician: To the aminer: On the b	Due to (c Due to (c Due to (c) Due to (c) Pue to (or as a consequence of a conse	t 3 DOA Otto	26. Place of her: 4 Nursing at rk? 1 Yes 2 Nume, date and opinion, death	of Death (Check of Sing Home 5 1 28d. Describe 28f. Locat City of I place, end due to	Now Person of the Cause (s) and place	3 Probably 24b. Were et available complet of death 1 Yes ther (Specify) urred manner es stated.	Unknown utopsy findings e prior to ion of cause ? 2XXNo



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Yee **Physician** 0634 Walter Albert Scott, Sr. 1999 pr.1 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Elkton Ceci1 Union Hospital If Under 24 Hrs. 8. Dete of Birth (Month Day, Year)

Dec • 20 , 1925 If Under 1 Year 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 10 M 2□ F Months Days 219-18-5594 73 Yrs Director Maryland Usual Residence of Decedent the Marylend 10c. City, Town or Location 10d. Inside City Limits 10e State 10b County mast be notified at Y□ Yes 2□ No Md. Cecil Director Elkton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code parmit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 2 and highery or other traumatic event, the Mod call Engine or must be no once. 413 Delaware Avenue 21921 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Yes 27 No f Yes, Give White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Chrysler Corp. Electrician 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ira V. Scott Clara Mackenzie 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 19a. Informant's Name/Relationship (Type, Print) Grand-Samantha A. Winward Daughter 102 Button Woods Rd., Elkton, Md. Method of Disposition

20b. Place of Disposition (Name of cemetery, cremetory or other place)

Possition 5 Other (See it)

20b. Place of Disposition (Name of cemetery, cremetory or other place)

1 Possition 5 Other (See it) 20a. Method of Disposition Date 20c. Location - City or Town, State 4/17/99 Cherry Hill, Md. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Fur Stilvice Licansee 259 E. MaIN Street Gee Funeral Home Elkton, Md. 21921 23a. Part1. Enter the drease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart in lure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Cancel disease or condition resulting in deeth) 3 Examiner Examine physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence of) d for use as t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? been signed by the should be deteched 2 No 1 TYas 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy Completed perlormed' this certificete has ral director, page 2 2 No 1 ☐ Yes 2 ☐ No 1 TYes Hospital or Attanding Physician: 24 hours efter death. Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) exeminer? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, offica building, etc. (Specify) in by 4 Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end menner stated. 29a. Certifier edicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and 4+119 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) Peoples Dyza GLASBOW De T. nothy Duite 32 O · Dannel 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 1 6 1999 State Registrar

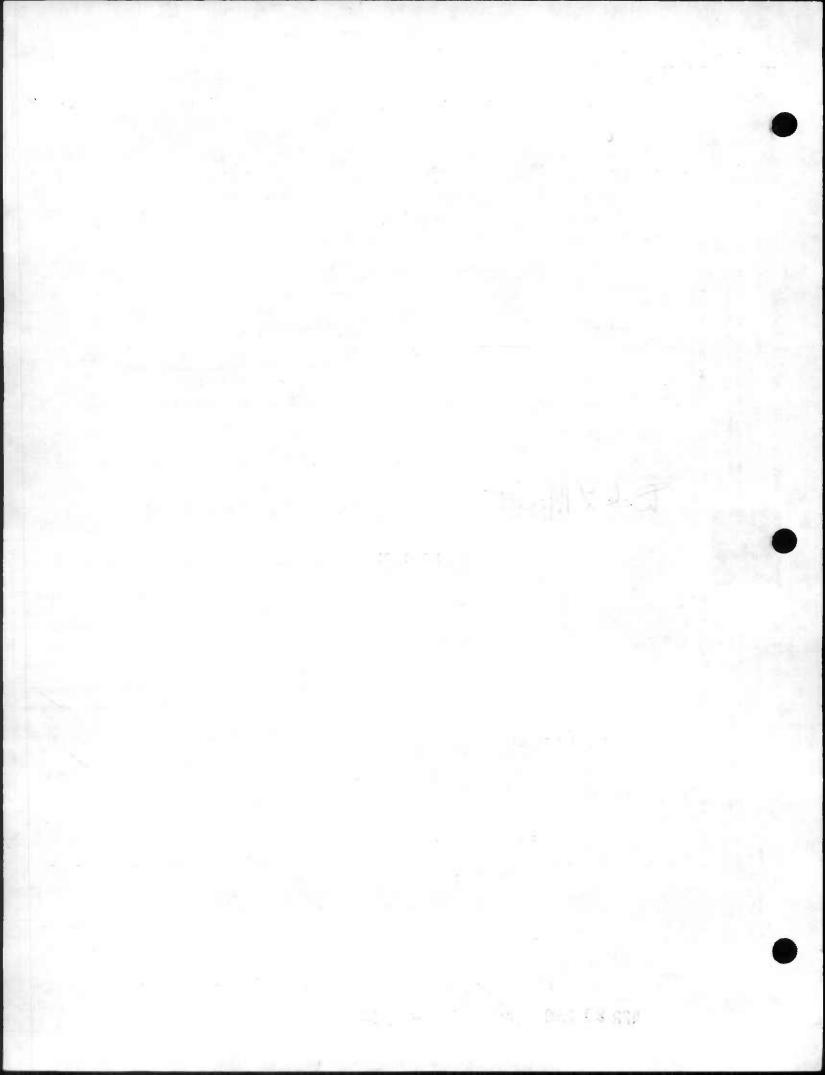
I A RESIDENCE TO SECURE

	PART I, 27 PERMEO G	Last)	WIV.	Oel	rtificate	OI L	Jean	2.	Date of Deat			3. Time of	Death
an cal	Jerry 4a Facility Name (If not institution,	Way		S	tonema		h City Tow		Month APRIL ion of Death	Day 23,	Year 1999 by of Death	0700	AM
ner 	2808 PHELPS AV	VENUE					FORES	STVILI	Æ	PRI	VCE GE		
	5. Social Security Number 212–54–2584 Usual Residence of Decedent	S. Sex NOM 2□ F	7. Age (In yrs. 50	last birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, Sept.	Year)		ace (State of ny) ningto	
tor	10a. State 10b. County Maryland Prince	George!s		ty, Town or Lo	stvill	l o	157				10	0d. Inside C	
al Directo	10e. Street and Number 2808 Phelps Aven			TOTE	10f. Zip 0		7	7 U.S.A.					
by Funeral	11. Marital Status 1X Never Married 2 Marrie 3 Widowed 4 Divorced	12. Wes Deced Armed Ford TOXYes If Yes, Give Year or Da	2 No 19	200	Was Decede if Yes, specif 1□ Yes 2		spanic Orig n, Mexican, Specify:	jin? (Specif , Puerto Ric	cify Yes or No- lican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White				
Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-	de completed) College (1-4or 5+)		kind of work DO NOT use	ent's Usual Occupation ind of work done during most of working O NOT use retired)				16b. Kind of I			
0 89 0	12 17. Father's Name (First, Middle, Li Eddie Lewi		Stonem		ehouse	e Ma	18. Mother		irst, Middle, I				e Par
	19e. Informant's Name/Relationshi Lewis D. Stone			609	Garne	er A	venue	Wald	orf, M	City or Town	n, State, Zip		
	20a. Method of Disposition 1 Magarial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funcial Service Economic 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Application of State Vetera 22. Name and Address of Face of Disposition (Neme of cemetery, cremetory or other place) Application of State Vetera 22. Name and Address of Face of Disposition (Neme of cemetery, cremetory or other place) Application of State Vetera 24 Donation 5 Other (Specify) 25 Name and Address of Face of Disposition (Neme of cemetery, cremetory or other place) Application of State Vetera 26 Name and Address of Face of Disposition (Neme of cemetery, cremetory or other place) Application of State Vetera						teran	s Cem	Funera	l Home	enham, , Inc.	Mary	
il Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a	Due to (d	CLEROTIC or as a conseq or es e conseq	quence of):	VASC	ULAR D	ISEASE					
Physician/Medical	nat initiated events Due to (or as e consequence of): d												
by Physic	Part II. Other algnificant condition	s contributing to dea	th but not res	ulting in the u	nderlying ca	use give	en in Part I.			es 2□No		the cause eably 4	
Completed		-61						-	24a. Wes e perfor	med?	con	re eutopsy ilable prior i npletion of d leeth?	cause
Be	25. Was case referred to medical examiner?	Unani al				Lou			Check only or	16)	1/2	Yes 2□	No
cation: To	X⊠ Yes 2 No 27. Manner of Death 1 ØNatural 5 Pending 2 Accident investiga	28a. Date of (Month		28b. Time of Injury		c. Injury Work	4 LI NUI	280	5 Reside			")	T
Certif	3 Suicide 4 Homicide 6 Could no determin	ed 289. Place of building	g, etc. (Specif						Location (Si City or Town	n, Stete)			iber,
Aedical	(Check 2) (Check one) 2) (Check one)	Physician: To the bas caminer: On the bas and manne	is of examine		vestigation, i	n my op	oinion, deat		at the time, d	ate and place	, and due to	the cause(s	3)
2	29b. Signature and title of certifier 29c. License number 0.C.M.E								2	9d. Date sign APRII	23,		

to the state 70,0000

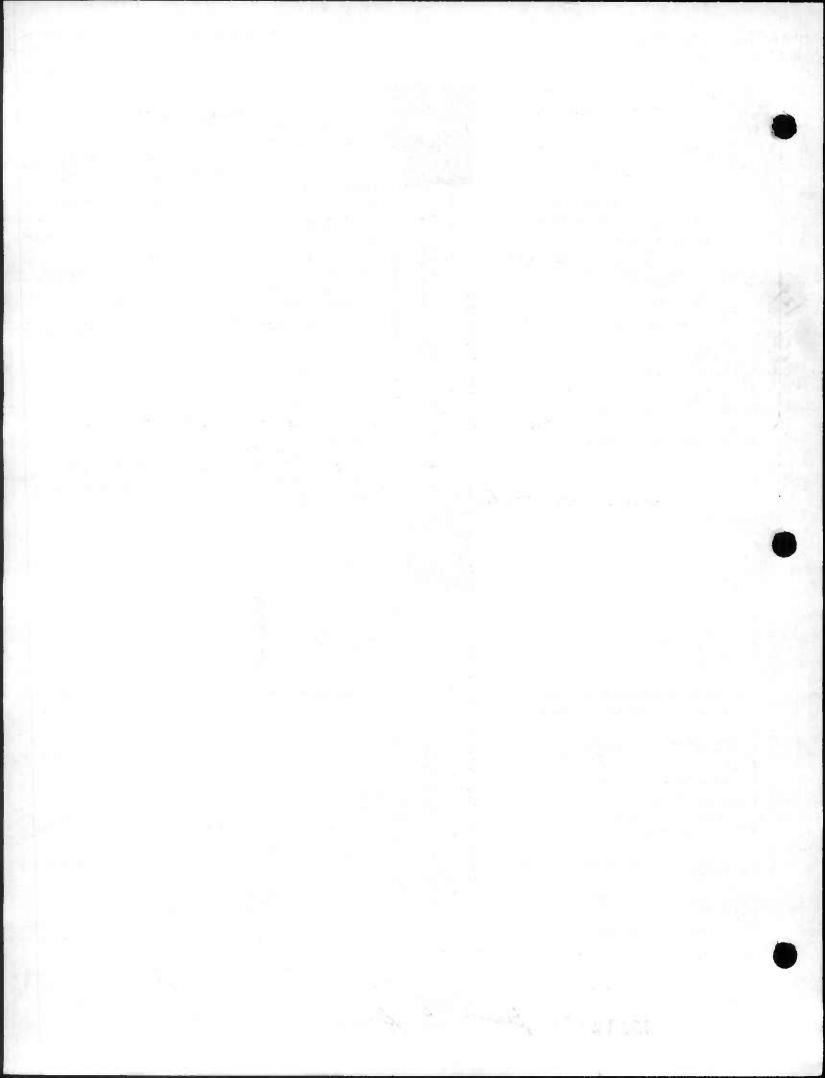
1. Develorit a realite (1 trat, micche, Li					- 1	2. Date of Dea	ath		3. Time of Death		
JOSEPH EDWARD	1. Decedent's Name (First, Middle, Last) JOSEPH EDWARD SMIGELSKI JR.							9 ^{Year}	2:05 A.M.		
		/									
5. Social Security Number 6.		rs. last birthday) Yrs.	If Under 1 Year Months Days					9. Birthpi	Birthplace (State or Foreign Country) LLINOIS		
Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation					10	Od. Inside City Limits		
MARYLAND ALLEGA	NY	CUMBERL	AND					₩ Ye			
10e. Street and Number			10f. Zip Code						try?		
118 BLAUL STREET		110			-2.40						
1 Never Married 2 Married 3 Widowed	Armed Forces? 1/El Yes 2 No	YEYes 2 No			10						
15. Decedent's E	ducation	16a. Deced	ent's Usual Occup	ation	of workir	na l	16b. Kind of B	usiness/inc	lustry		
Elementary/Secondary, (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	d)			TÉHCK I	DETVE	p		
17. Father's Name (First, Middle, Las	1)	TROOK	DRIVER	18. Mother	's Name						
JOSEPH E. SMIGEL	NNOR										
	(Type, Print)	19b. Mailin	g Address (Street	and Number	or Rura	Route Numbe	er, City or Town,	Stete, Zip	Code)		
ANNA MAE COLE	MOTHER			RIVE N	.E.						
1 ☐ Burial 2 ☐ Cremation 3 [Removel from State	cemetery, cren	etory or other place) D. T.T.						
		22	Name and Addre	es of Facility	,			KLAND	MARYLAND		
Pol YI	- H							TET A NIT			
23a. Pari1. Enter the disease, or con	riplications that caused the de							ILAND	Approximete Intervel Between		
Continues and State									Onset end Death		
disease or condition resulting in death) a. DRUG INTOXICATION Due to (or es a consequence of):											
										Sequentially list conditions,	bDue to
Cause (Disease or injury	c							1			
that initiated events resulting in death) Last	Due to	Due to (or es e consequence of):									
Part II. Other significant conditions	Dat II Other similinant conditions contribution to doubt but not moulting in the underlying sauce given in Rad I							ontribute to	the cause of death?		
Turn. Outsi agrinoani outsions	on mouning to doubt but not not	osonary at the or	loonyang oddood gre	on arr dit.							
CARDIAC HYPE	RTROPHY								are autopsy findings allable prior to		
							/	of	mpletion of cause death?		
05 111	T							18	Yes 211 No		
examiner?	Hospital: 1 Inpatient 2	☐ FR/Outnation	3 DOA Oth	10C				ner (Snecit	w)		
27. Manner of Death	28a Date of Injury	28h Time of							,,		
2 Accident investigation	4-18-99	FOUND 2:			-		UNKNOWN				
	building, etc. (Spe						vn, State) 1		AU STREET		
	miner: On the basis of exami										
29b. Signature and title of cardier	A	711	29c. Licens	se number			29d. Date signe	ed (Month,	Dey, Year)		
D-PO	tanen	MI) o.c	.M.E.			April 1	9, 19	199		
30. Name and authors of person who	completed cause of death (tt		Print)								
Steden	Postaine	er 1	11 Penn	Street	Ba	altimor	e, Mary	land	21201		
31. Date filed (Month, Day, Year)	32. Registrar's Sig	Santa									
for management and	1.18 Bl.au Street 5. Social Security Number 217-76-4678 Usual Residence of Decedent 10a. State 10b. County MARYLAND ALLEGA 10e. Street and Number 118 BLAUL STREET 11. Marital Status 1 Never Married 2 Married 3 Widowed XX Divorced 15. Decedent's E (Specify only highest or Elementary/Secondary, (0-12) 17. Father's Name (First, Middle, Las JOSEPH E. SMIGEI 19a. Informant's Name/Relationship ANNA MAE COLE 20a. Method of Disposition 1 Burial 2 XI Cremation 3 Id Donation 5 Other (Species) 21. Signature of Funeral Service Les only the sease or condition resulting in death) 23a. Part I. Enter the disease, of conshock, or heart failure. List only the sease or condition resulting in death) CARDIAC HYPEI 25. Was case referred to medical examiner? 1 May leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other algnificant conditions of the conditions of the condition of the	1.18 Bl.au Street 5. Social Security Number 2.17-76-4678 2.18-20-10-20-20-20-20-20-20-20-20-20-20-20-20-20	1.18 Blau Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 217-7-9-4608 218-7-9-4608 219-7-9-	1.18 Blau Street Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 217-76-4679 With the property of the property	S. Social Security Number S. Sax T. Age (in yrs. last birtholay) # Under 1 Yes. Hunder 2 17 7-6-48 79 Hunder 2 17-76-48 79	1.18 BLau Street S. Social Security Number 6. Sax 217-7-6-4673 1217-7-6-4673 1217-7-6-4673 1217-7-6-4673 1217-7-6-4673 1217-7-6-4673 1218-1217-7-6-4673 1218-1217-7-6-4673 1218-1217-7-6-4673 1218-1217-7-6-4673 1218-1217-7-6-4673 1218-1217-7-6-4673 1218-1217-7-6-4673 1218-1217-7-6-4673 1218-1217-7-6-4673 1218-1217-7-6-4673 1228-1217-7-6-4673 1238-1217-7-6-4673 1248-1217-7-6-4673 1258-1217-7-6-4673 1268-1217-7-6-4673 1278-1217-7-6-4673 128	118 BlauLStreet 5. Social Society Number 6. Social Society Number 6. Social Society Number 7. Age (in yrz. last biorholdy) 6. Social Society Number 7. Age (in yrz. last biorholdy) 7. Age (in yrz. last biorholdy) 7. Age (in yrz. last biorholdy) 8. Social Society Number 7. Age (in yrz. last biorholdy) 8. Social Society Number 8. Social Society Number 8. Social Society Number 10. Social Society Number 10. Social Society Number 10. Social Society Number 11. Most and Social Society 12. Social Society 13. Social Society 14. Social Society 14. Social Society 15. Decodering Social Social Society 16. Social Society 17. Father's Name (First, Abdde, Last) 19. Social So	1.1 Blaut Street S. Social Security Number S. Soci	1.18 Blau Street S. Social Security Number 2. Special Security Number 3. Special Security Number 4. Special Security Number 5. Special Security Number 6. Special Security Number 7. Special Se		

Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiana

			Otato of Ivial	ryland / Depa <i>Cel</i>	tificate of			Reg. No.	1.4	U.S. I
Physic	ian	1. Decedent's Neme (First, Middle, Last)					2. Date of Dee Month	Dey	Yeer	3. Time of Death
/Medi	cal	Shirley Ann Th				4b. City, Town, or I	April			2010
Funeral Director	ner	Sunrise Care & 5. Sociel Security Number 6. Sec	Rehabil	itation (In yrs. lest birthday) 54 Yrs.		Elkton If Under 24 Hrs. Hours Min.	8. Dete of Birth	Cec	9. Birthpla	ica (Stete or Foreign
2011-100-11		Usual Residence of Decedent					Jan. 2.	J, 1745	DOVCE	, 00
show dat	_	10a. Stete 10b. County	}	10c. City, Town or Lo					100	d. Inside City Limits
Ne M	Director	Maryland Ken	t		Gale	ena				1 ☐ Yes AND
the or	급	10e. Street end Number 33609 Sassafras	Coldwall E	Road	10f. Zip Code 216.		10g. Citizen of V U.S		yı	
within 72 hours after death with the Maryland jene. than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at	by Funeral	+	12. Wes Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	ver in U,S. 13. V	pecify Yes or No- o Rican, etc.)					
d within 72 hours a giene. ir than "naturel", o the Medical Exam	Completed t	15. Decedent's Edui (Specify only highest grade Elementary/Secondery (0-12)	Yeer or Detes: cation e completed) College (1-4or 5+)	16e. Deced (Give life. L	king					
D D b T		17. Fether's Neme (First, Middle, Last)			Disable		ne (First, Middle,	N/A		
ad a b	o Be	John Thornley					Mae Wae		18/	
d 2 should b th and Ments 7 is marked traumetto e	To	19a. Intorment's Neme/Reletionship (Ty	pe, Print)	19b, Mellin	ng Address (Street				Stete, Zip C	>ode)
and 2 ath a 27 is ar free		Rhesa Antone/G	Guardian	PO Bo	ox 207,	Clayt	on, Del	aware	1993	8
Pages 1 and nent of Healt int: If item 2 ary or other		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emovei from State	20b. Pleca of Dispo- cametery, cren Chesapeak						
permit. Departri Importa any injk		21. Signeture of Fuherai Servica License 23a Pert1. Enter the disease, or complishock, or heert affure. List only or	ss of Facility	9 M	- F] [[.	D A			
ificate be axecuted g physician and es the burial-transit	ledical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest		ue to (or es e conseque to (or es e conseque	•					
aath certific attending p	clan/N		l						i	
he lew requires that the de a has been signed by the age 2 should be deteched	y Physician/M	Pert II. Other eignificant conditions con	/		nderlying cause giv	ren In Pert I.		obacco use co		the cause of death
ew requir	Completed by	hyperten			en eutopsy med?	com	e eutopsy findings lable prior to pletion of cause eeth?			
	Com	mental re	fanda	fin			1 🗆 Y	es 28 No	10	Yes 2□ No
iclan: The certificata rector, peg	Be	25. Wes case referred to medical examiner?					eth (Check only o	ne)		
\$ 000	To	1 ☐ Yes 2 Ž(No	ospitel: 1 ☐ Inpatient 28a. Dete of Injury	2 ER/Outpetien 28b. Time of		4 Jap Housing In	lome 5 Resid			
20 0 0	Certification:	1 ⊠Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be determined	y et k? Yes 2 □ No	28d. Describe h	itreet end Numb		Route Number,			
To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: After completely filled in by the fun	edical Cert	29e. Certifier 12G Certifying Phys	building, etc.	my knowledge, deeth xaminetion and/or inv	occurred et the tin	ne, dete end place plnion, deeth occu	city or Tow , end due to the c	ceuse(s) end me	enne <i>r</i> es ste	ted. he cause(s)
ithin 2 or the xmple	Med	one) 29b. Signeture end title of certifier	end menner stete	d.	29c. Licens			29d. Dete signe		
	10	· MEllenet	ram, M		03	5779		Apri	15,	1999
		30. Neme end eddress of person who co		oth (Item 23a) (Type, I	Print) -1 5, 80	hemia	Ave, le	c: 140	n, n	nd 2191
Sta		31. Dete filed (Month, Dey, Year)	32. Registrer		1					



an	23 PART I, 27 PER MEO 1. Decedent's Neme (First, Middle, L		•		cate of		2. Date of D			3. Time of Death	
	AUSTIN CHARLE	S THUSS					APRII	Day 22, 199	Year	01:45 PM	
eal er	4a Facility Name (If not institution, gi	ive street and number)				4b. City, Town, o	or Location of Dea		-	01.45 111	
	14515 MICHAEL R	OAD				CUMBER	LAND	ALLEC	ANY		
	5. Social Security Number 219-53-2439 6.	Sex 7. Ag 1 ☑ M 2 ☐ F 4:			Inder 1 Yea onths Days			irth Jay, Year)	9. Birthplac	e (Stete or Foreign	
		12 4	MON	1113/is. 4	16		DEC 6	1998	W.VA.		
	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Locatio	n				10d	. Inside City Limits	
101	MARYLAND ALLEG	ANY	CUM	BERLAND						1□Yes 2□No	
Directo	10e. Street and Number			10	f. Zip Code			10g. Citizen of	What Country		
	14515 MICHAEL RO	OAD			21502			U.S.A			
Lamera	11. Marital Status	12. Was Decedent Armed Forces?	nt Ever in U.S. 13. Was Decedent of			Hispanic Origin?	(Specify Yes or N		ck. White, etc.		
	1 Never Married 2 Merried	1 Yes 2 T	ło	7-10	es 2 No		orto rucari, etc.)	Specif			
	3 Widowed 4 Divorced	Year or Dates:			2X 11	o opeany.		Specif	WHIT	'E	
Desaiduros	15. Decedent's E (Specify only highest gi	Education rade completed)	100	16a. Decedent's (Give kind	of work done	e during most of w	vorking	16b. Kind of B	usiness/Indus	stry	
1	Elementary/Secondary (0-12)	College (1-4or 5	+)		OT use retir	90)					
	17. Father's Name (First, Middle, Las	(t)		INFANT		18. Mother's N	ame (First, Midd	INFANT e, Maiden Suman			
o Be	KENNETH DALE TH										
-	19a. Informant's Neme/Relationship			19b. Mailing Ad	dress (Stree	et and Number or	KAY TWI		State. Zio C	ode)	
	KENNETH DALE THI	USS FAT	HER	14515 M				ND MARYL			
	20a. Method of Disposition		20b. P	lace of Disposition emetery, cremator	(Name of		Date	20c. Location			
	1 ☑ Burial 2 ☐ Cremetion 3 [4 ☐ Donation 5 ☐ Other (Spec			NSET CEMI			26 1999	CUMBERLA	ND MAI	RVIAND	
	21. Signature of Funeral Service Lie			22. Na	ne and Add	ress of Facility	1	o oxio Ditto	1110	NI DIMID	
	130 9 I	110				DAMS FUN					
cal Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury										
- 1	that initiated events resulting in death) Last	Due to (or as e consequence of): d									
riiyaiciarymed	Part II. Other significant conditions	contributing to death be	t not resi	ulting in the underl	ring cause g	given in Pert I.	23b. Di	d tobacco use co	ntribute to ti	he cause of death?	
							10	Yes 2 No	3 Probei	bly 4 Unknown	
							044 381	s an autopsy	24h Warn	eutopsy findings	
								formed?	comp	able prior to pletion of cause	
								/	of de		
a completed	25. Wes case referred to medical						16	Yes 2□No	101	res 2□ No	
z	examiner? 1 [XYes 2 No	Hospitel: 1 Inpatie	ot all	ER/Outpatient 3	DOA O	Whor	Home 5 17 Re	rone) sidence 6 □Oth	or (Conside)		
	27. Manner of Death	28a. Date of Inju	у	28b. Time of	28c. Inj		1	a how injury occur			
2		on (Month, Da)	(Year)	Injury N		ork? Yes 2 No					
2	1 🖾 Natural anding 2 ☐ Accident vestigation							(Street and Numi own, State)	t and Number or Rural Route Number, tate)		
Certification: To B		289. Place of Inju	. (эрван)								
Certification: To	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Exa	building, etc. hysician: To the best of miner: On the basis of	f my knov	wiedge, death occ	urred at the ation, in my	time, date and pla	ce, and due to th	e cause(s) end m	enner as stet and due to th	ed. ne cause(s)	
edicai Certification: To	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	building, etc	f my knov	wiedge, death occ	ation, in my	opinion, death oc	ce, and due to the	e, date and piece,	and due to th	ne cause(s)	
	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Exa	building, etc. hysician: To the best of miner: On the basis of	f my knov	wiedge, death occ	ation, in my 29c. Licer	opinion, death oc	ce, and due to the	a, date and piece, 29d. Date signe	and due to the	ne cause(s) ny, Year)	
edical Certification: To	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	hysician: To the best of miner: On the basis of and manner ste	of my know examinated.	wledge, death occion and/or investig	29c. Licer	opinion, death oc	ce, and due to th	e, date and piece,	and due to the	ne cause(s) ny, Year)	

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death Month Day 5:45 p.m. 1999 George William Usilton, Sr. April 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Magnolia Hall Nursing Home Chestertown 6. Sex 1 M 2 □ F If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Yrs. October 30, 1926 Maryland 10c. City, Town or Location 10d. Inside City Limits Yes 2□ No Chestertown 10f. Zip Code 10g. Citizen of What Country? United States 21620 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 22 ANo If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes XXNo Specify: Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Maintenance Highway Administration

18. Mother's Name (First, Middle, Maiden Surname)

Fellows, Helfenbein & Newnam Funeral Home, P.A.

Elkridge, Maryland

Approximate Interval Between Onset end Death

lar.

Lillian Mae Darrell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1012 Morgan Station Drive, Severn, Md 21144

20b. Place of Disposition (Name of cemetery, crematory or other place) April 13, 1999

20c. Location - City or Town, 1999

the Maryland 28a-f show r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Director permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygene. Important: If Hem 21's marked other than "natural", or Items 23s any injury or other traumatic event, the Hadres Examine man Funeral Baltimore, Maryland 21215-0020 þ Be Completed

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Neme (First, Middle, Last)

5. Social Security Number

Maryland

11. Marital Status

10e. Street and Number

10a. State

212-32-2746

200 Morgnec Road

1 ☐ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☑ Divorced

Elementery/Secondary (0-12)

17. Fether's Name (First, Middle, Last)

George Washington Usilton

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

19a. Informant's Name/Reletionship (Type, Print)

Paul Anthony Tessicini

4 Donation 5 Dother (Specify)

Dail Stockard

31. Date filed (Month,

MD

32. Register's Signature

6

20a. Method of Disposition

Immediate Ceuse (Final disease or condition resulting in death)

21. Signature of Funeral Service

10b County

Kent

Usual Residence of Decedent

Physician /Medical Examiner

Physician/Medical Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettending physician end use es the buriel-transit Completed Be 10 Certification: filled in by

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	Due to (Pla Ji'a or as a consequence'o Itiple (1) or as e consequence of	/A					
Part II. Other significant conditions of						ontribute to the cause of death		
					24a. Was en eutopsy performed?	24b. Were autopsy findings evailable prior to completion of cause of death?		
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				1□ Yes 247No	1 ☐ Yes 2 ☐ No		
25. Was cese referred to medicel examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpetient 3 [Other		ath (Check only one)			
27. Manner of Deeth 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury M		me 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory)	28f. Location (Street and Num City or Town, Stete)	28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)				
29a. Certifier (Check only one) Certifying Physics Medical Example 1	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre ation end/or investigation	d at the time, on, in my opinio	lete end place n, death occu	a, and due to the cause(s) and m urred et the time, date and place	enner as stated. and due to the cause(s)		
29b. Signature and title of certifier	00002	2	9c. License nu D 50	mber 996	29d. Date sign	ed (Month, Day, Year)		

Meadow Ridge Memorial Park

22. Name and Address of Facility

William L. King, Jr. 4-90937 370 Cypress Street, PO Box 270, Millington, Mary and Schock, or heart failure. List only one ceuse on each line.

spiretion langed Raspivetory failure

100 Brown St. Clastertown MD 21620

State Registrar

129 SOTIE 4/12/79.

Dail Stadland IND 100 Brown St. Charte How, MD 21620

State of Maryland / Department of Health and Mental Hygiene

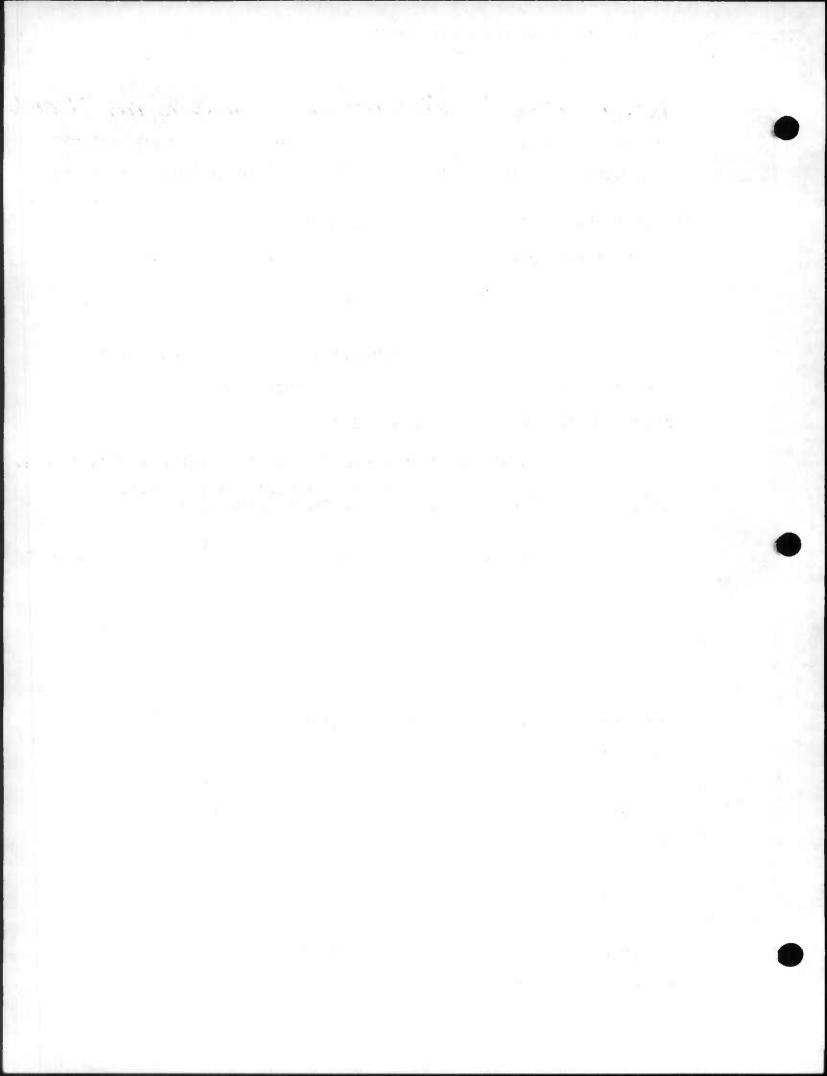
		Certificat	e of Death	Reg. No.	14024			
	Decedent's Nama (First, Middle, Last)			te of Deeth onth Dey Ye	3. Time of Deeth			
Physician /Medical	Herman W. Voshell, Sr.		Apr		3:55 p.m.			
Examiner	4e Fecility Neme (If not institution, giva street end number)		4b. City, Town, or Location	of Death 4c. County of D				
	Magnolia Hall		Chestertown					
Funeral	5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ge (In yrs. last birthday) If Undar Months	T 1 Yaar If Under 24 Hrs. 8. Da Deys Hours Min. (M.	te of Birth 9. onth, Dey, Year) ember 31, 1908 M	Birthplece (State or Foreign Country)			
Director	Usuel Residence of Decedent	Itaa	aller or, room	IIII gui, no				
yland	10e. Stete 10b. County	10c. City, Town or Location			10d. Inside City Limits			
Mar Mar	Maryland Kent	Millington			X□Yes 2□No			
U sifer death with the Ma viteme 23e or 28e-1 signed from the rottles.	10e. Street end Number 329 Cypress Street	10f. Zip	21651	10g. Citizen of Whet	t Country?			
ne 2:	11 Manital Status 12. Was Decedent	Ever in U,S. 13. Was Dacer	dent of Hispanic Origin? (Specify Yo cify Cuben, Mexican, Puerto Rican,		American Indien,			
by Fr.	1 Nevar Marriad 2 Married 1 Yes 2 3 Widowed 4 Divorced Armed Forcas 1 Yes 2 1 Yes 2 2 1 Yes 2	No	city Cuben, Mexican, Puerto Rican,		White, atc. White			
2 ho	15. Decedent's Education	16a. Decedent's Usua	el Occupation	16b. Kind of Busine	ess/industry			
Ind 21215-0020 be filed within 72 hours af lal Hyglene. d other than "natural", or event, the Medical Exam Be Completed by F	(Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or	5+) Clerk	rk done during most of working se retired)	Agricultu	iro			
H Hyging	17. Fether's Name (First, Middla, Last)	OICIN	18. Mother's Name (First	, Middle, Meiden Sumeme)	ше			
Maryland 212 d2 should be filed with th and Mental Hygiene. 77 is marked other than traumatic event, they To Be Come	James Voshell		Hanna Jones					
should should in marked umatic	19e. Informent's Name/Reletionship (Type, Print)	19h Malling Address	9b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Cod					
Mar d 2 sho th and 7 is m traum	Herman Voshell, Jr./Son			21.651				
1 end 1 end Health em 27 other tr	20e. Method of Disposition	20b. Placa of Disposition (Ner	me of Det		y or Town, Stete			
mant. Pages 1 and 2: Apparement of Health at Mornant: If item 27 is my injury or other traines	1 XX urial 2 □ Cremetion 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify)	Millington As	bury Cemetery 4/	11/99 Milling	gton, MD			
	21. Signature of Funeral Service Licensee 23e. Pert1. Enter the disease, or complications that cause shock, or hear failure. List only one cause on each i	Fellow 370 W.	nd Address of Fecility S, Helfenbein & Cypress Street, de of dying, such es cerdiac or resp	Millington.				
Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in deeth)	Ner more Dua to (or as a consequenca of):			<2 Y ARI			
thet the death certificate be assocuted edby the attending physician end detached for use as the burial-transit Physician/Medical Examinel	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest							
Box (authoring attending for use a	d							
daat daat daat se att	Part II. Other significant conditions contributing to death b	out not resulting in the underlying of	cause given in Pert I. 2	23b. Did tobacco use contribute to the cause of death?				
IS, F.C. BOX as that the death ce igned by the attendi be deteched for use by Physician/	SEVERE DE	EMENTIA		1 Yes 2 No 3	Probably 4 Unknown			
requir			2	4a. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of causa of deeth?			
The law ate hes b page 2 s				1 Yes 2 No	1 ☐ Yes 2 ☑ No			
- F ad O	25. Wes case referred to medical		20 21 12 1 (2)		10 162 26 140			
VICAL TREC sician: The law centificate hes t lirector, page 2 s	exeminer? Hospital:		26. Place of Deeth (Che		(0			
in Of Vital ing Physician: T ifter this certificat uneral director, p	1 Yes 2 10 10 10 10 10 10 10 10 10 10 10 10 10	ury 28b. Time of 2 Injury 2	28c. Injury et Work?	i ☐ Residenca 6 ☐ Other (a escribe how injury occurred	Specify)			
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (2 Accident investigation 3 Suicide 6 Could not be determined 28e. Plece of In building, e	jury - At home, ferm, street, factor cc. (Specify)		ocation (Street end Number of ity or Town, State)	or Rural Route Number,			
To the Hospital within 24 hours To the Funeral completely filled Medical Co	29a. Certifier (Check only 2 Medical Examiner: On the basis of	of examination end/or investigation	et the time, date end plece, end du , in my opinion, deeth occurred et t	e to the ceuse(s) end menne he time, date end place, end	er es steted. I due to the ceuse(s)			
thin 2 the Pomplet	one) and manner si	leted.		29d. Date signed (M	14			
	29h Signature and title of certifier	~ MD	c. License number	4/9	199			
6	Name and eddress of person who completed cause of	teath (Item 23e) (Type, Print)	Jan Md	21620	,			
State Registrar		sar's Signature 9. A	parks					

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State of Maryland / Department of Health and Mental Hygiene

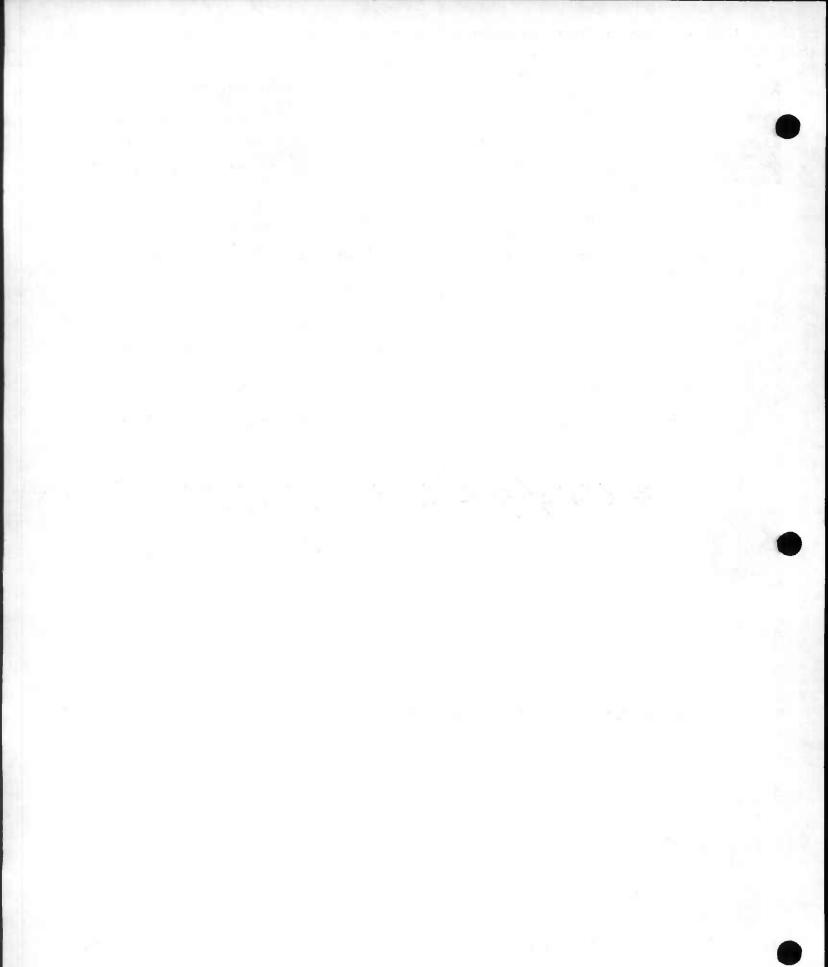
Certificate of Death 1. Decedani's Nama (First, Middla, Last) 2. Data of Death **Physician** VIOLANT Month 4pril 16, /Medical 4a. Facility Nama (If not institution, give streatland number 4b. City, Town, or Location of Deeth 4c. County of Daath Examiner 2515 ANN ARBOR LANE BOWIE PRINCE GEORGES 7. Aga (In yrs. last birthdey) If Under 1 Yaar if Under 24 Hrs. 8. Data of Birth Months Days Hours Min. (Month, Day, 5. Social Sacurity Number 9. Birthpiaca (Stata or Foraign Country) NEW JERSEY 6. Sax **Funeral** Days 1□M 2□F Yrs. 82 Director 140-05-5430 OCT.8,1916 Usual Rasidance of Decedant with the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "nature!", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 ☐ Yas 2 ☐ No Director MARYLAND PRINCE GEORGES BOWIE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2515 ANN ARBOR LANE 20716 U.S.A. death v 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American indian, Biack, Whita, atc. permit. Pegas 1 and 2 should be filed within 72 hours after toppertment of Heelth end Mental Hygiene. Important: If Item 27 is marked other than "naturelt, or ther any Injury or other traumatic event, the Medical Exercise. 1 Navar Married 2 Married 1 Yes 2 No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ▼ No þ Specify: WHITE 3√2 Widowed 4 □ Divorced Completed 16a. Dacedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER OWN HOME 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Surname) Be ORAZIO CARDILLO CHRISTINA PAPA 19a. informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) JOSEPH VIOLANTE-SON SAME AS #10 20b. Piace of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Othar (Specify ENTOMBMENT HOLY CROSS CEM. 4-21-99 NORTH ARLINGTON, N.J. 22. Nama end Addrass of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarvel Betwaen Onsat and Daath **Physician** /Medical Immadiate Causa (Final Cardiac arrhythmi Immediate disease or condition rasulting in death) Examiner Examiner attending physician and for use es the bunal-transit Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Diseasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequance of): be axec P.O. Box 68760, Physician/Medical Due to (or es a consequança of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? signed by 1 3 Probably 4 Unknown 1 Tyes 2 No Uypertension, previous cardiac arrhitenia Records. by 24b. Wara eutopsy findings aveilabla prior to complation of causa of death? 24a. Wes an autopsy performed? Completed Breast cancer 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica 25. Was casa rafarrad to medical Be 26. Piece of Death (Chack only ona) Othar: 4 Nursing Homa 5 Masidance 6 Othar (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in by the funeral 28c. Injury at Work? 27. Manner of Daath 28a. Data of Injury (Month, Day Year) 28b. Time of Certification: 28d. Dascribe how Injury occurred 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 ☐ Accidant 6 Could not ba 3 ☐ Suicida 28f. Location (Streat and Numbar or Rural Routa Numbar, City or Town, Stata) 28a. Placa of Injury - Al homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicida 1 Certifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and place, and due to tha ceusa(s) end mannar as stated. 29a, Cartifia Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and manner stated. 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signad (Month, Day, Year) Yana U. Muscorich MD 30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print) Tara T. Muscovich MD 1438 Dekase Hwy Gambrills, MD 21054 32. Registrar's Signatura 31. Date filed (Month, Day, Year) State **APR 19** Registrar



State of Maryland / Department of Health and Mental Hygiene

								Cer	titicat	e or i	Death			Reg. No.			
Phys	sician		s Nama (First, Mic										2. Data of Da Month	Day	Year	3. Ti	ma of Daath
	edical	d Leota Mary wanting											April	12, 199	9	5:0	00 p.m.
	miner		ama (If not institut							4	b. City, To	wn, or Lo	cation of Deat	h 4c. Count	y of Deat	th	
		101 Morgnec Road, Apt K-101 (Residence) Chesterto									Kent						
Fune Direct		224-64		6. Sax 1 □	. Sax 1 M 2 F 7. Aga (In yrs. 85			Months Davis Hours Min					8. Data of Bi	iy. Year) 1913	9. Birthplaca (Si Country) 1913 Decatur, II		tata or Foraigi J
and		10a. Stata	nce of Decadant 10b. Coun	ty		10	c. City, Tow	n or Lo	cation							10d. Insi	da City Limits
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daath me 2		11. Marital St			2. Was Dad	cedant Eva	r in U,S.	13. V	Vas Daced	lant of H			cify Yas or No		ce - Ama	rican India	an,
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tant:		4 Donation 5 □ Other (Specify) Anatomy Board 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility								/13/99	Baltim	ore,	MD				
Semil. Pages 1 ar Department of Heal montant: if Item 2	BOU	21. Signature	o of Funeral Service	e License	1/	11	1	22 Fe	Nama an	d Addra	ss of Facili	ty nhoin	& Nova	nam Fun	oro1	Home	D A
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To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: Attar this cartifical completely filled in by the funeral director.	tion: T	27. Mannar o	f Death ral 5 ☐ Pend	fing stigation	28a. Data		28b.	Tima of Injury	-	8c. Injur Wor		1		how injury occu		спу)	
DIVISION OF VITAL RECORDS, if or Attending Physician: The law requires the after death. Director: After this cartificate has been signed of in by the funeral director, page 2 should be e	Certification:	3 Suicida 4 Homicida 6 Could not be determined 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)							4	28f. Location (City or To	Straat and Num wn, Stete)	ber or Ri	u <i>ral Ro</i> uta	Number,			
To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: Aftar thi completely filled in by tha funeral	Medical C	29a. Certifiai (Check o	1⊠ Cartify 2 Medica	ring Phys at Examin	er: On that	e best of m basis of exa	amination en	a, daath d/or inv	occurred astigation,	et the tin	ne, dete ar pinion, dee	nd place, a oth occurre	and dua to tha ed at tha tima,	cause(s) end m data and place	anner es	s stated.	use(s)
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Yeer 5 1999 APLIL **Physician** MARIE D0215 WILES 10=45 AM /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner HOSPITAL FALLSION HARFORD FALLSTON GENERAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 9. Birthpleca (State or Foreign Country) **Funeral** 1 ☐ M 2 🖸 F Director 212-30-8275
Usuel Residence of Decedent Nov. 28, 1932 Maryland with the Marylenc 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f abov trsumstic event, the Modical Examinar must be notified at 1 Yes 2 No Maryland Baltimore Towson Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 6 Airway Circle 21286 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Experient angles. Bleck, White, etc. 1 Never Merried 2 Married Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White by 3€ Widowed 4 Divorcad Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Registered Nurse Health Care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Jefferson Bowling Zimmerman Thomas Margaret (nmn) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 802 Grayson Ct., Bel Air, MD 21014 Janet Hofherr/ Daughter Baltimore, 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Emmanuel U.M. Cemetery 4-9-99 Laurel, Maryland 22. Name end Address of Fecility 21- Separture of Funeral Servica Licansee Howard K. McComas III Funeral Home, P.A. 50 W. Broadway Street, Bel 1 Parties of Street, Bel 1 Parties on each line. 50 W. Broadway Street, Bel Air, Maryland 21009 23a. Pert1. Enter the shock, or heart four Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel ASCVID diseese or condition resulting in death) Examiner Due to (or es e consequence of): Examiner buriel-transit the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last pue Due to (or es e consequenca of): physician Physician/Medical the Due to (or es e consequença of) 98 signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy MYOCARDIAL INFARCTION 1 Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Naturel 2 Accident il or Attending s after death. il Director: Aft 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homleide To the Hospital owithin 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, dete end placa, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature end title of cartifier 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) FULFORD ANE SEZAIR MO 21014 NABHU M.D 218 31. Dete filed (Month, Day, Year) 32. Registrar's Signature Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) 3. Tima of Death **Physician** /Medical County of Death not institution, give street and number) 4b. City, Town, or Location of Death Examiner ENTER If Under 1 Yaar Months Deys 9. Birthpleca (Stata or Foraign Country) 01 8. Data of Birth (Month, Day, Year) May 25, 19 If Undar 24 Hr 5. Social Security Number 7. Aga (In vrs. last birthday) 6. Sax **Funeral** 1⊠M 2□ F Hours 64 Maryland Director 217-24-8944 1934 Usuat Residence of Deceden with the Meryland 10a Stata 10b County 10c. City, Town or Location 10d. tnside City Limits item 27 is marked other than "natural", or hema 23a or 28a-f show other treumatic event, the Madical Examiner must be notified at Md. 1 Yas No Director Anne Arundel Glen Burnie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 103 Gatewater Ct. USA 21060 deeth Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 X Yas 2 □ No If Yas, Giva Yeer or Detes: 1954 – 56 Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. 11 Marital Status Black, Whita, atc. filed within 72 hours after of Hyglene. Then "naturel", or he 1 X Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White Àq 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 ahould be filed with Department of Heelth and Mental Hyglen important: if item 27 is marked other that any injury or other treumatic event, the page. Teacher Public Schools 17. Fether's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be George Wayson Grace King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 29 St. Michael Dana Point, CA 92629 Edward Owen Wayson / brother 20b. Placa of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1) Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) 4-17-99 Mt. Zion Cemetery Lothian, MD. 22. Name end Address of Fecility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service License 147 Duke of Gloucester St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Onset and Death **Physician** /Medical tmmediata Causa (Final diseasa or condition resulting in death) 30 MINUTES MBOLISM Examiner Dua to (or es e co Examiner attending physicien end for use es the burial-transit The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760 Physician/Medicai Due to (or es e consequence of) P.O. Part tf. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records, p 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24a. Was an eutopsy performed? has page 2 2 No 1 ☐ Yas 2 ☐ No 1 Yas 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: Inpatient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA

this certificate To the Hospital or Attanding Physicien: within 24 hours effer deeth.

To the Funerel Director: Affer this certifica completely filled in by the funeral director, I

2 Certification:

edical

29a. Certifie (Check only one)

1 Yas 2 No 27. Manper of Death 1 Natural

5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 Homicide

28a. Data of Injury (Month. Day Year)

28b Time of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No 28a. Plece of tnjury - At homa, farm, street, factory, offica building, atc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Carifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of pertil

29c. License numbe

29d. Data signed (Month, Day, Year)

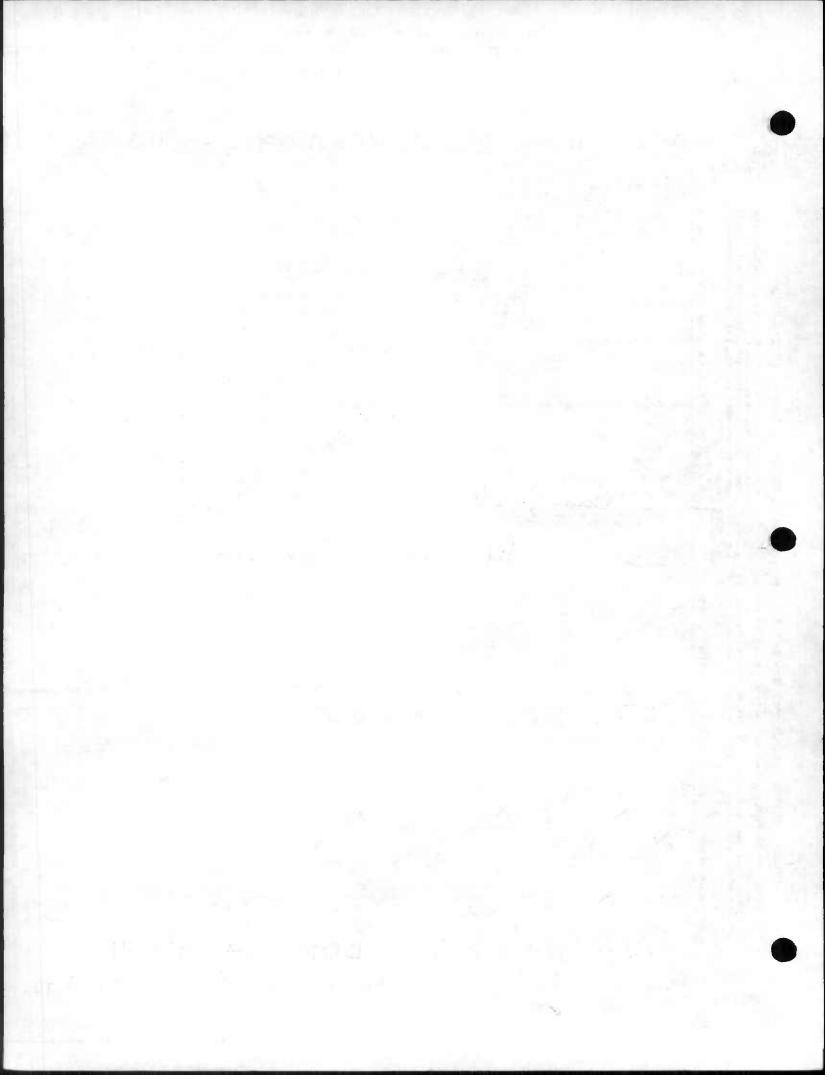
rson who completed causa of death (Item 23a) (Type, Print) . Name and

600 Ridge 31. Data filed (Month, R 16 1999

32. Registrar's Signature

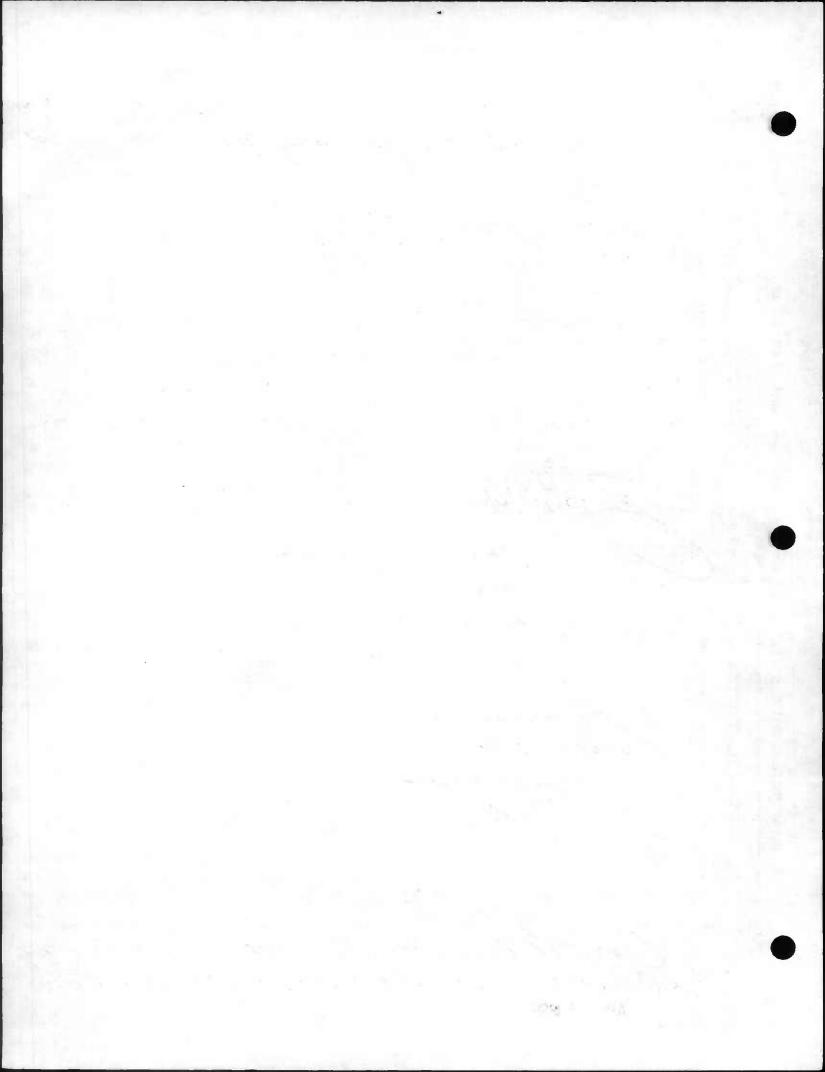
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State Registrar



State of Maryland / Department of Health and Mental Hygiene ()

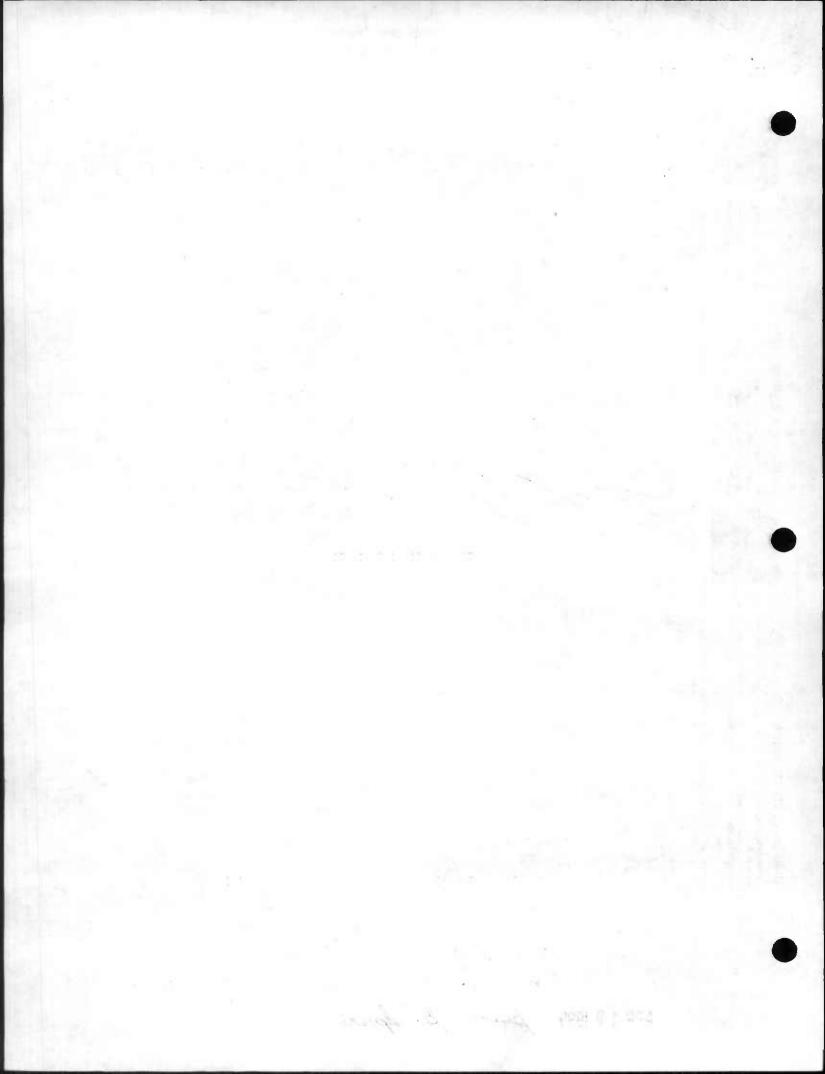
	Certificate of Death	Reg. No.
	Decedent's Name (First, Middle, Last)	2. Deta of Death Month Day Year 3. Time of Death
Physician /Medical Examiner	Harold Martin Wasson 4a Facility Nama (If not institution, giva street and number) 4b. City, Tow	wn, or Location of Death 4c. County of Death
	5 Social Security Number 6 Say 7 And I'm yes lest high day	freme are menos
Funeral Director	5. Social Security Number 6. Sex 1EJ M 2 F 7. Age (In yrs. last bidifiday) 1 Under 1 Year 1 Under 2 Hours 1 Security Number 7 4 Yrs. Usual Residence of Decedent	Min. B. Data of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country) Mar 29, 1925 Indiana
death with the Maryland ms 23a or 28a-f show f.ms.t.be notified at neral Director	10a. Stata 10b. County 10c. City, Town or Location	10d. Inside City Lim
1 1 0	MD Anne Arundel Severna Park	1 □ Yas 2√2
or 28a-f a	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
23a or 28a-1 ahow	104 Lochleven Drive 21146	USA
P. Fu	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, specify Cuban, Mexican, If Yes, Give Year or Dates: 1 □ Yes 2 ☑ No Specify:	pin? (Specify Yas or No- Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. Specify: White
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ond Mental Hyge marked other urnatic event,	John F. Wasson Car	rie L. Goin
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127 127	E. Eileen Wasson / wife 104 Lochleven Dr.	ive, Severna Park, MD 211
nant of Ha unt: If flaen ary or oth	20a. Mathod of Disposition 1 Buriat 2 Cremation 3 Memoral from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cametery, crematory or other place) Hall Cemetery	Apr 16 Blue Mound, IL
sed by the stending physician and detached for use as the burial-transit and y Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting or death) Due to (or as a consequence of): Cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): C. Last Due to (or as a consequence of): d. Last Due to (or as a consequence of):	Corner Descare
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ata has b page 2 si	Massel free.	1 Yas 2 No 1 Yes 2 No
is certificata director, pag To Be Co	25. Was case refarred to medical axaminer?	of Deeth (Check only one)
5 D	1 Yas 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nu 27. Manner of Death 28a. Deta of Injury 28b. Time of 28c. trijury at	rsing Homa 5 Rasidence 6 Othar (Specify) 28d. Describe how injury occurred
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rs after death. al Director: After tied in by the funara Certification:	3 Suicide 4 Homicide 6 Could not be detarmined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	281. Location (Street and Number or Rural Routa Number, City or Town, Stata)
within 24 hours after death. To the Funeral Director: After the completaly Illied in by the funeral Medical Certification:	29a. Certifier (Check only ane) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2. Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deat and manner steted.	d place, and due to the cause(s) and manner es stated. th occurred et the time, date end plece, end due to the ceuse(s)
To the Com	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	Very Holacen Mid D467	201 april 13 199
	30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	2126
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State	31. Data filed (Month, Day, Year) 32. Registrar's Signature	in-a, working - wo
Registrar	APR 1 6 1999 Server D. Annual	



State of Maryland / Department of Health and Mental Hygiene Ian Michael Wells Certificate of Death ITEMS: #23 PART I, 27, 28A-F PER MEO G770 4-30-99 WR. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 15, Ian Michael Wells April 1999 8:54 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 8 Red Pump Road Rising Sun Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign County) NOV. 24, 1978 NEW JELSEY 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Yrs. 20 148-68-3294 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Haulth and Mariel Hyglans. Important: if item 27 is marked other than "natural", or hems 23s or 28s-f show any injury or other treumstic event, the Madical Example market horized at page. 10s State 10b. County 10d. Inside City Limits 1 Yes 2 No Directo Maryland Cecil Rising Sun 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Red Pump Rd. 21911 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 1. Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: 21215-0020 Py 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Musician Music Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Robert K. Wells Kathleen J. Tomasso 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Robert K. Wells/Father 8 Red Pump Rd. Rising Sun, MD 21911 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □YBurial 2 □ Cremetion 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4-20-99 Brookview Cemetery Rising Sun, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911 23a. Part . Enter the disable shock, or heart land or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) ACUTE NARCOTIC INTOXICATION Examiner Due to (or as a consequence of) Examine physicien end the burial-trensit be axacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury liber initiated assets) Due to (or as a consequence of) Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 080 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Junknown 2 Records, by 24a. Was an autopsy performed? Completed 24b. Were autopsy findings available prior to Dee0 completion of cause of death? 2 No Pres 2□ No cartificata Vital director. 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA N☐ Yes 2☐ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To Division of the After the 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? i or Attanding F after deeth. I Director: After d in by the funer 5 Pending investigation Injury UNKNOWN 1 Natural Found: 15-99 1 Tyes 2 No 2 Accident UNKNOWN 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8 RED PUMP ROAD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours after Funeral Dire letely filled in b To the Hospital of within 24 hours at To the Funerel D completely filled in FOUND AT HOME RISING SUN, MARYLAND edical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 16, 1999 Church no 3 30. Name and address of person why pleted cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 te ennis , mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

1 9 1999 **DHMH 16 Rev 6/95**



ammended Harfd a co Health Dept. Line # 12 April 22, 1999 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedant's Name (First, Middle, Last) 3. Time of Death 10:15pm **Physician** Christian Fielder Younker April 7, 1999 /Medical 4e Fecility Neme (If not institution, giva straat and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Harford Memorial Hospital Havre de Grace Harford If Undar 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Dey, Year)
March 11, 1924

9. Birthplece (Stete or Foreign Country)
Pennsylvania If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **X**XM 2□ F Months Deys Yrs. **Director** 198-16-7557 Usuel Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MXYes 2□ No Directo Maryland Harford Aberdeen 10e. Straat and Number 10f. Zip Code 10g. Citizen of What Country? 487 Roberts Way 21001 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. XIXYes 2 No 15 68 If Yes, Give Year or Dates: 42-6 1 Never Married 2 M Merried Specify: White 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) U.S.Government Military 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) permit. Pages 1 and 2 should be till. Department of Health and Mental Hi Important: If Item 27 is merked oth any injury or other traumatic even Slyvester Younker Frances Baer 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Ingeborg Younker (wife) 487 Roberts Way, Aberdeen, MD 21001 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) R.A. Ferris & Company 4/9 West Chestet, PA 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23e. Pert1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart fellure. List only one cause on ecordine. Approximata Intervel Between Onsat and Daath Physician /Medical Immediate Ceusa (Final disease or condition resulting in death) e. AUTE MYOCARDIAL INFARCTION

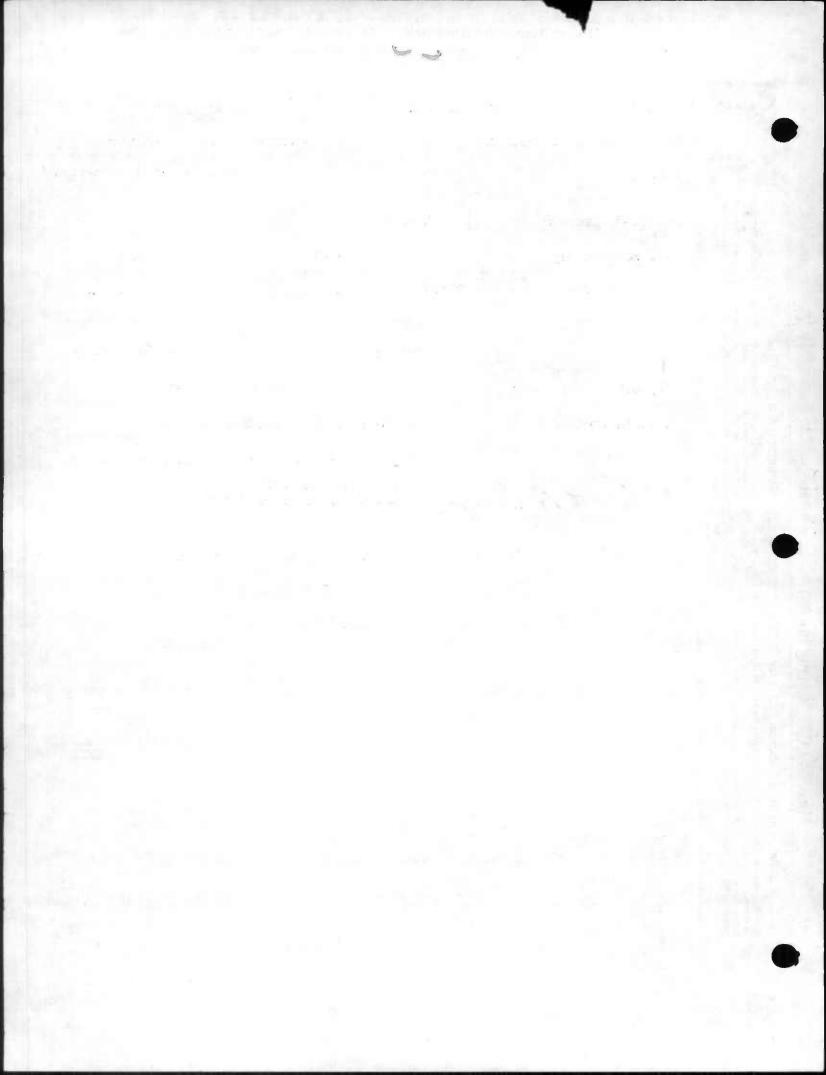
Due to (or es e consequence of): Examiner Physician/Medical Examiner RESPIRATORY FAILURE

Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting In deeth) Lest c. CHRONIC BSTRUCTIVE CUNG-Due to (or as e consequence of): DISEASE of Vital Records, P.O. Box 68760 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Onknown by 24b. Wera autopsy findings available prior to completion of ceuse of daeth? 24a. Was en eutopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 27. Manner of Death 28e. Date of Injury (Month, Dey Year) Certification: 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation Natural 1 Yes 2 No 2 Accident after deeth 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated. 29e. Certifier Medicai (Check only one) To the Within 2 29c. Licensa number 29d. Date signad (Month, Dey, Year) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Are Harre dograce 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signature

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1. Decedent's Name (First, Middle, Last)

permit. Pagas 1 and 2 should be lifed within 72 hours aftar death with the Marylan Department of Health and Mantal Hygiana. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any lighty or other traumatic event, the Mad call Examinating the north once. **Physician** /Medical **Examiner**

physician and the bunal-transit The law requires that the death certificate be executed Records, P.O. Box 68760 attanding pl signed by the aid be detached le been sig ils cartificata has I Division of Vital Hospital or Attending Physician: 24 hours after daath.
Funeral Director: After this cartifice ataly filled in by the funeral director, it To the Hospital or within 24 hours aft To the Funeral Di complataly filled in

Physician April 22 1999 2:40 A.M. Edward Henry Alsurhe /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner VA MEDICAL CENTER, FORT HOWARD MD 21052 FORT HOWARD If Under 24 Hrs. 8. Da BALT 'IMORE 5, Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) **Funeral** Months Deys 1⊠M 2□ F Hours Min. Yrs. Director 212-03-0682 BALTIMORE, MD Usual Residence of Decedent 10a. Stete 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 2005 E. Belvedere Ave. U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1★ Yes 2 ☐ No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. Never Merried 2 ☐ Married 1 Yes 2k No Specify: Specify: White py 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 0 Cab driver Transportation 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Helene C. Kirchner Henry A. Alsruhe 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Pauline Alsruhe/sister 2005 E. Belvedere Ave., Baltimore, MD 21239 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme end Address of Facility Ronald S. Wade, State Anatomy Board, 655 W. Baltimore Street 21201 Baltimore, Maryland 21201

23a. Parl: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Baltimore, Maryland Approximate interval Between Onset and Death Immediate Cause (Final DIFFUSE LARGE CELL LYMPHOMA 2 YEARS diseese or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or es e consequence of): Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION g 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy performed? HERPES ZOSTER 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 ☐ Yes 2 ◯XNo To 28a. Date of Injury (Month, Dey Year) 28c. injury et Work? Certification: 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 SNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and manner stated. 29a. Certifier edical 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number April 22, 1999 247804 M.D owier. 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) ANDREW MROWIEC, M.D., VA MEDICAL CENTER, FORT HOWARD, MARYLAND 21052 31. Dete filed (Month, Dey, Year) 32. Regisfer's Signeture State 1999 new Registrar

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No

Day

3. Time of Death

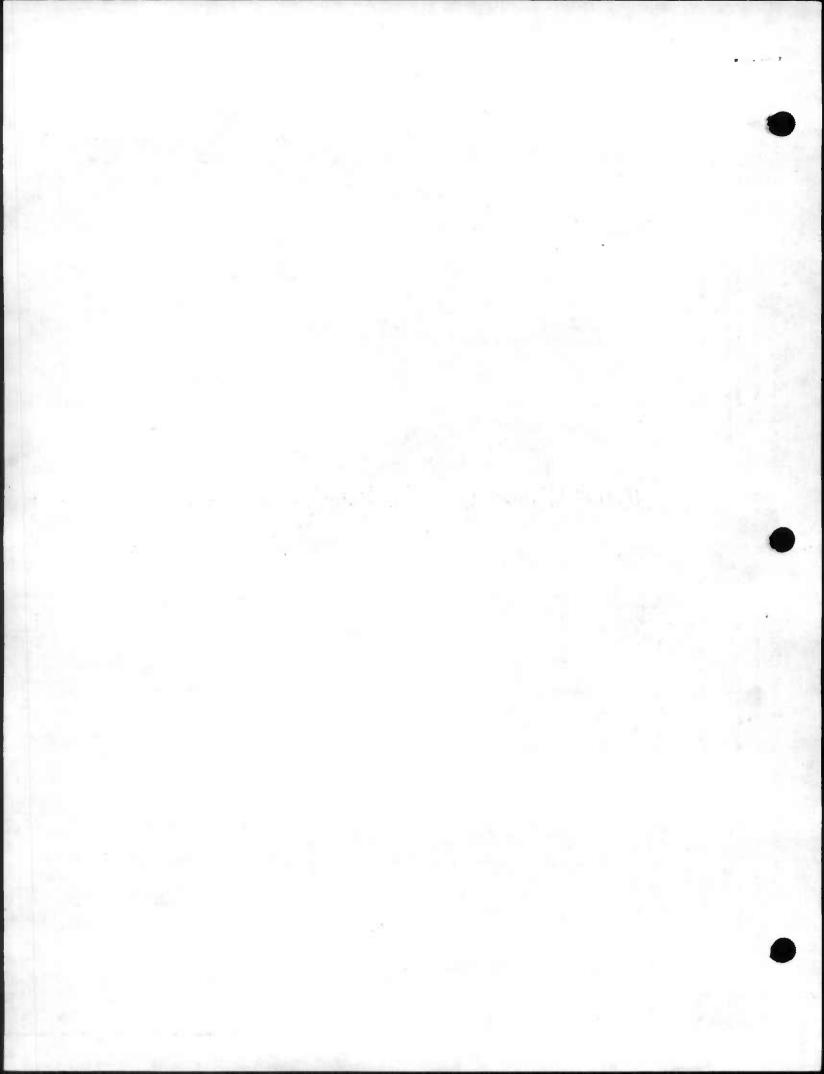
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Apri Kuns 1999 2:57 DW /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Baltimore HMORE iberty 6. Sex If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1√2 M 2□ F Yrs. Director 87 214-05-1730 marionstation Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 4313 FAIRFAX ROAD 21216 U.S.A. fterns 23a Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Black, White, etc. 72 hours after 1 Yes 2 No
If Yes, Give A
Year or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturally plury or other traumatic event, the Mental PAGE. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) PAINTER SELF EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALBERT ATKINS ELLA BROWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Ralationship (Type, Print) STEPHANIE GIBSON (NEICE) 4313 FAIRFAX RD, BALTO. MD 20e. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 5-3-99 LANDSDOWN, MD MT ZION CEMETERY eral Service Lie 22. Name and Address of Facility LEROY O DYETT & SON FUNERAL HOME 21207 4600 LIBERTY HGHTS AVE. BALTO. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** prostate Cancer with spinal mets Immediate Cause (Final diseasa or condition rasulting in daeth) /Medical Examiner Examiner physician and s the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disaese or Injury that initieted events resulting In death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): ed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ or Attending Physician: The law requires 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed COPI 2 12 No 1 Yes 2 No 1 Yes 25. Wes case raferred to medical axaminar? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 24 hours after death.

Funeral Director: After thi letely filled in by the funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Neturel 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigetion 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of tnjury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) To the I 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 29 D44089 uner anus 30. Neme end addrass of person who completed cause of geath (Item 23a) (Type, Print) LIGON -NUNEZ ZUDO LIBERTY HEIGHTS AVENUE RHAMIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar loouts



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item # 16a per FH G771 5/5/99 gap 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Vee ALSTON 4b. City, Town, or Location of Deeth UTOPIA 11.58 PM 16th 1999 4e Facility Neme (If not institution, give street end number) 4c. County of Death Baltimore N If Under 24 Hrs. 8. Date of Birth Hours Min. Month, Dey, Year) March 10, 1968 BON 58cours Hospital If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthdey) 248 1□M 2XF Months Deys 86 31 216 Yrs. Usuel Residence of Decedent 10d. Inside City Limits 10e Stete 10h County 10c. City, Town or Location 1 Yes 2 No N 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 930 roll ton 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married 1□ Yes 2□ No Specify: 3 ☐ Widowed 4 ☐ Divorced Lack 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Unknown 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) cial 12+11 WOLKE UNK. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Capitalia NYOL Jackson 19a. Informent's Name/Relationship (Type, Print (Socie) Work) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) LOTE Ha Marshall (FTIEND) 3007 E. Biddle St. Baltimore, MD Marshall Baltimore, MD 21213 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location · City or Town, Stete 20e. Method of Disposition Dete 1 Buriel 2 Cremetion 3 Removal from State 4-27-99 LandsdoWNE ZION 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY 22. Name and Address of Fecility 21. Signeture of Juneral Service License GARY P. Marc Baltmore 270 FREdh. Iton Pass Mg ranc enoc 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest speck, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final e. Enostage Acquired Immune Deficiency Syndrome disease or condition resulting in death) Pneumonia Bilateral TWK Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) zdays Overwhelming Due to (or es a consequence of): Poly substance Abuse 24 rs. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one)

Physician /Medical Examiner

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

edicai

29b. Signature end title of certifier

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer death v. Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a and injury or other traumatic event, the Medical Examiner mans once.

Baltimore, Maryland 21215-0020

the Marylend

/Medical

Director

Funeral

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Completed

physician end the burial-trensit The law requires that the deeth certificate be axecuted Division of Vital Records, P.O. Box 68760, ed by the e been signed by should be detac page 2 this certificate : After this certifica s funeral director, r

Hospital or Attending Physician: To the Hospital or Attendir within 24 hours aftar deeth. To the Funeral Director: Af completaly filled in by the fu deeth.

Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending 1 ☐ Yes 2 ☐ No Investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner es steted.
2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) and manner stated. 29a. Certifier

29c. License number

29d. Date signed (Month, Dey, Yeer)

Attending

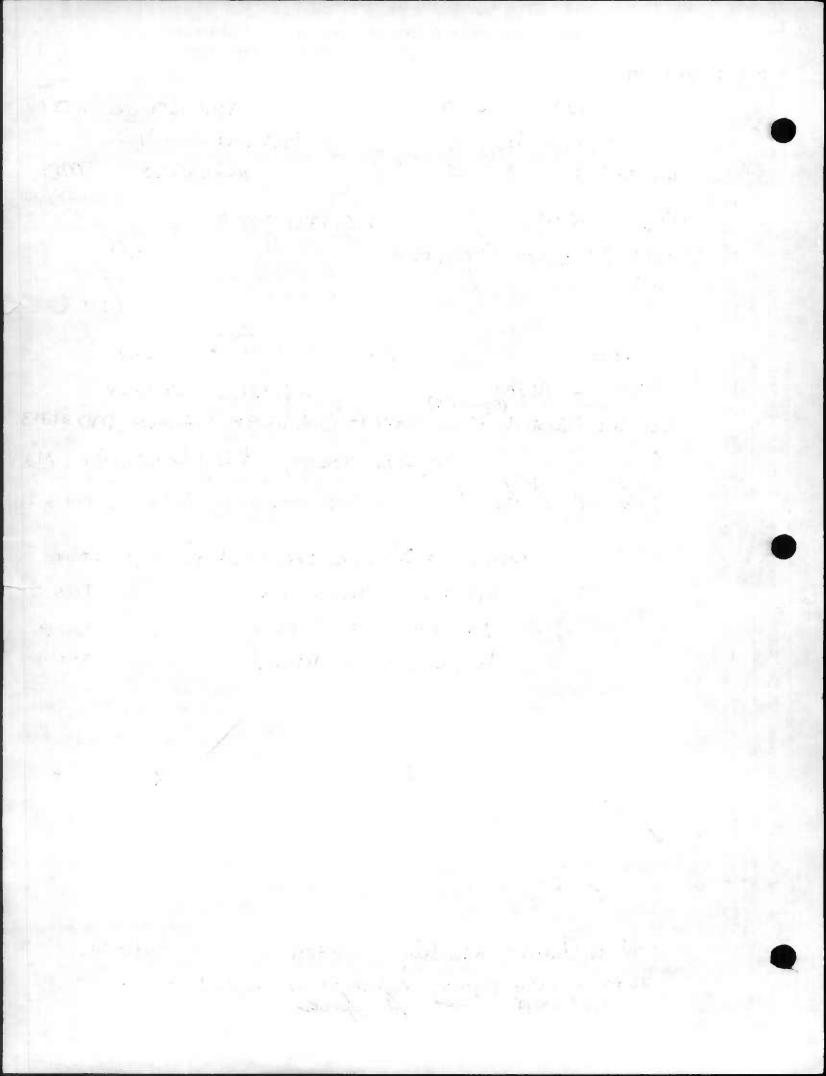
16199 D38993

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Hahts
32. Registrer's Signature Ciberti

Baltimore Maryland

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** ABEL LORETTA APRIL 28, 1999 10:15 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL N/A BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Birthplace (State or Foreign
Country) **Funeral** Year) Months Days Hours 1 M 2 F 217-19-8202 Yrs. 28 October 29, 1970 Maryland Director Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Heatth and Mantal Hygiana. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Madical Examined mantined at 1 ☐ Yes 2 No Maryland Baltimore Glen Arm Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7 Running Fox Road 21057 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: p White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dental Assistant Dental 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brian Lee Jaggers Margaret Victoria Schwartz 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles H. Abel / Step Father 7 Running Fox Road Glen Arm, Maryland 21057 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ACremation 3 Removal from State 5-1-99 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Mitchell-Wiedefeld Funeral Home, Inc. Steven T. Betth 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final RESPIRATORY FAILURE 6 DAYS disease or condition resulting in death) Examine Due to (or as a consequence of): Examiner DAYS ADULT RESPIRATORY DISTRESS SYNDROME physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): certificata be axec 10 DAYS VIRAL PNEUMONIA Physician/Medical Due to (or as e consequence of): 80 ACUTE MONTH GRAFT VERSUS DISEASE HOST USB Por Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. datached 23b. Did tobacco use centribute to the cause of death? Division of Vital Records, P.O. signed by t 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown POST ALLOGENEIC BONE MARROW ò TRANSPLANTATION 24b. Were eutopsy findings eveilebte prior to 24a. Was en autopsy performed? Completed peen completion of cause of deeth? paga 2 s 1 Yes 2 No 1 Yes 2 LA cartificata Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) funaral 27. Manne of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Aftar 1 Natural 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be determined n 24 hours after day le Funeral Director plataly filled in by the 3 ☐ Suicide Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 6 Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completaly (Check only one) 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated. To the Vithin 2

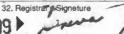
State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Gargun

GORGUN AKPEK, M.D.,



JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.

29d. Date signed (Month, Dey, Year)

28

21287

29c. License number

RES-000

APR 3 0 1999

201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box 68760

APRILL SER June 18 January

water complete the following of the con-

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April **Physician** 1999 Arlene Axelrod 2100 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** Genesis Eldercare - Spa Creek Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
9. Birthplaca (State or Fon Country)
March 27,1914
Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days Months Hours 1□ M 25 F 160-01-1417 85 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel 1 ☐ Yes 2 No Annapolis Director 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 35 Milkshake Lane Norma 23a 21403 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. filled within 72 hours after 1 ☐ Yes 2/2/No If Yes, Give 1 Never Merried 2 Married 8 Saltimore, Maryland 21215-0020 1 Yes XXNo Specify: Specify: White à 3 X Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 abould be fill ment of Health and Mental H aut; if them 27 is marked off lary or other traumatic even Be Joseph Dobrof Mamie Remins 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Cramer (Daughter) 7028 Channel Village Court, Annapolis, MD 21403 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ₺ Buriel 2 □ Cremetion 3 □ Removal from Stete Department of Important: If any Injury or once. Kneseth Israel Cemetery 04/29 Annapolis, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service-Licent 22. Neme and Address of Fecility Hardesty Funeral Home, P.A. also 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner MIC Movary be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai The law requires that the death certificate the Due to (or es e consequence of): esn signed by the e Pert tt. Other significant conditions contribyting to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 No 2 No 3 Probably 4 Unknown þ Records, 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Deeth 28a. Date of tnjury (Month, Dev Year) 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Time of After Division 5 Pending investigation 1 Haturel s aftar deeth. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end menner stated. within 2 ş 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ated cause of death (Item 23a) (Type, Print) 30. Name and address of person,

Registrar

DHMH 16 Rev 6/95

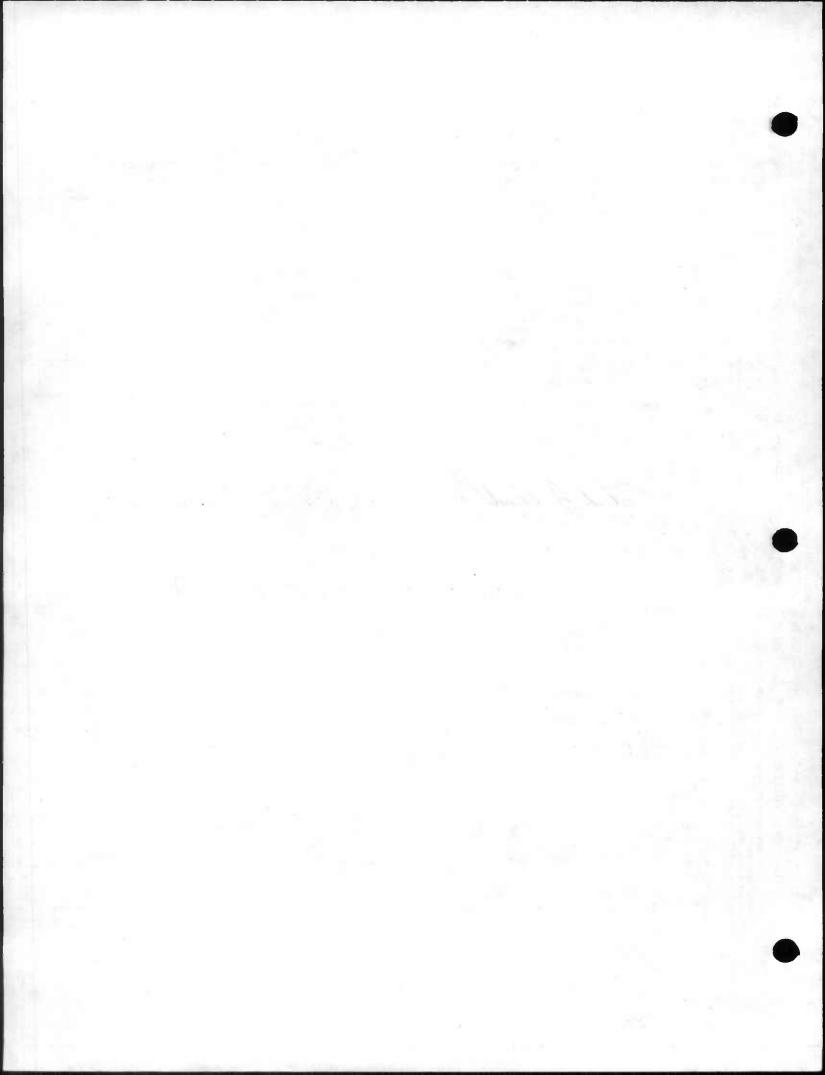
State

31. Dete filed (Month, Day,

1999

32. Registrer's Signeture

Innapolis, Md 21401 - Toseph



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiefie Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year **Physician** Maggie Donnia 1999 28 4:15 PM April /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of Forest Hill Hill Forest Harford 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Euneral** Days 1 M 2 F Months Hours 212-34-2617 86 Director June 27, 1912 Virginia Usuel Residence of Decedant with the Maryland 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits ahow r than "natural", or items 23a or 28a-f ahor the Medical Examiner must be notified at Maryland 1 ☐ Yas 2 No Harkord Joppa Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 406 Bonham Road 21085 U.S.A. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Merital Status 14. Race - American Indian, permit. Peges 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or iten sny injury or other traumatic avent, the Medical Evant Black, Whita, atc 1 Nevar Merried 2 Married 1 ☐ Yas 2 XNo If Yas, Giva altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ (No Specify: White Specify: g 3 □ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) 6th Grade College (1-4or 5+) Homemaker Own Home 17. Fathar's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Names Unknown) Lila Mae Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Roy Bourne 406 Bonham Road, Joppa, MD (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem'l Garden 15/1/99 Baltimore, Maryland 22. Nama and Addrass of Facility 21. Signeture of Funeral Sarvice Licensee Schimunek Funeral Home, Inc. Busin a Welley 23e. Part 1. Entar tha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21236 Approximate Intarval Batween Onsat end Death **Physician** /Medical Immediata Causa (Final LTW diseesa or condition resulting in daath) Examiner Examiner une physician and the burial-transit Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): 9 been signed by the attending should be detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2Q No 3 Probably 4 ☐ Unknown outi. à 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2Q No 1 ☐ Yas 2 No this certificate funeral director, 25. Was casa rafarred to medical axaminar?

1 Yas 2 No Be 26. Place of Death (Check only one) Other: Nursing Homa 5 ☐ Rasidence 8 ☐ Othar (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? Certification: After 5 Pending invastigation To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fun. Neturel 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide TS Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) end mannar es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, end due to the ceusa(s) and mannar stated. 29e. Certifier (Check only one) Medical 29b. Signetura end titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) Dav PS. D32299

4/41-4

DHMH 16 Rsv 6/95

State

Registrar

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615 W. MACPHA.

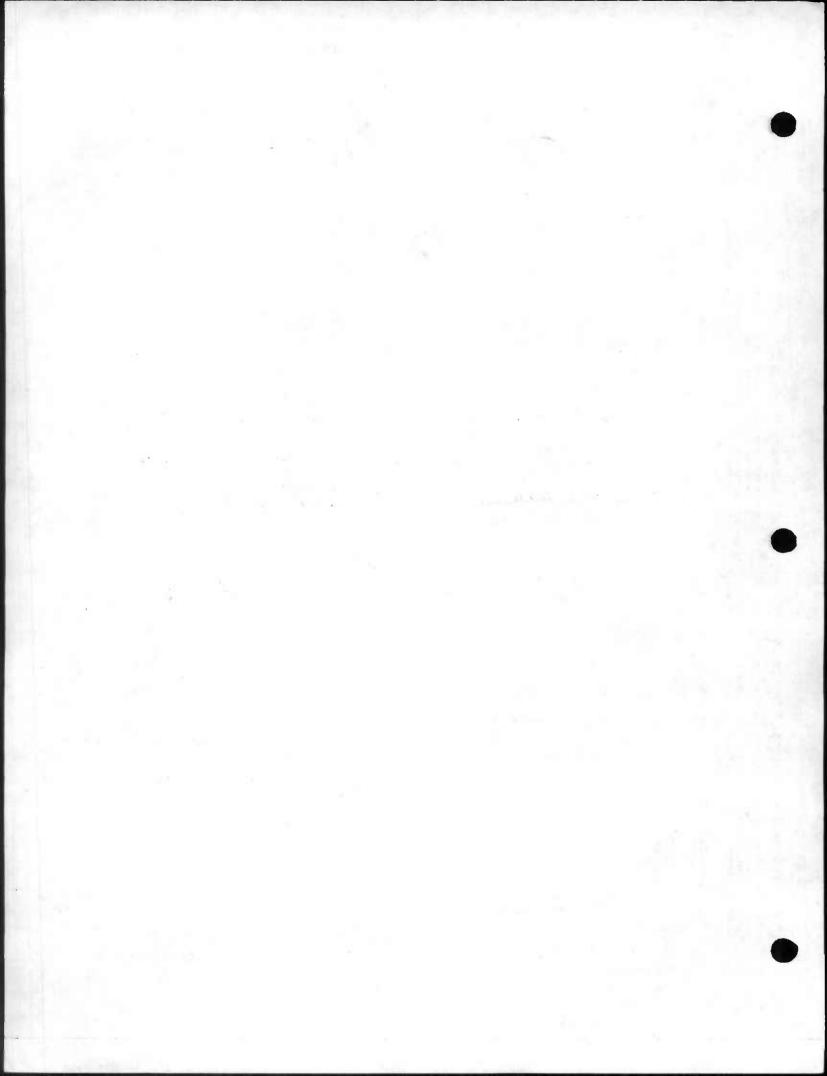
32. Registrar's Signatura

30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

5. DUNA

APR 3 0 1998

31. Data filed (Month, Day, Year)

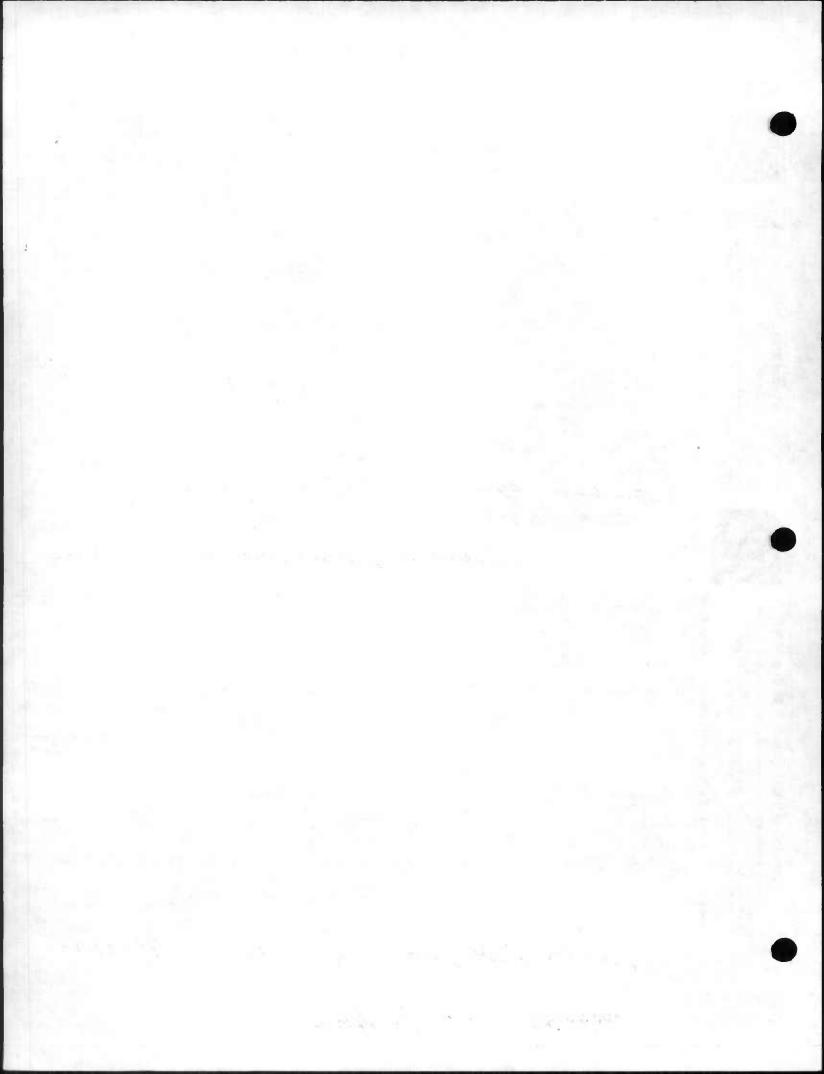


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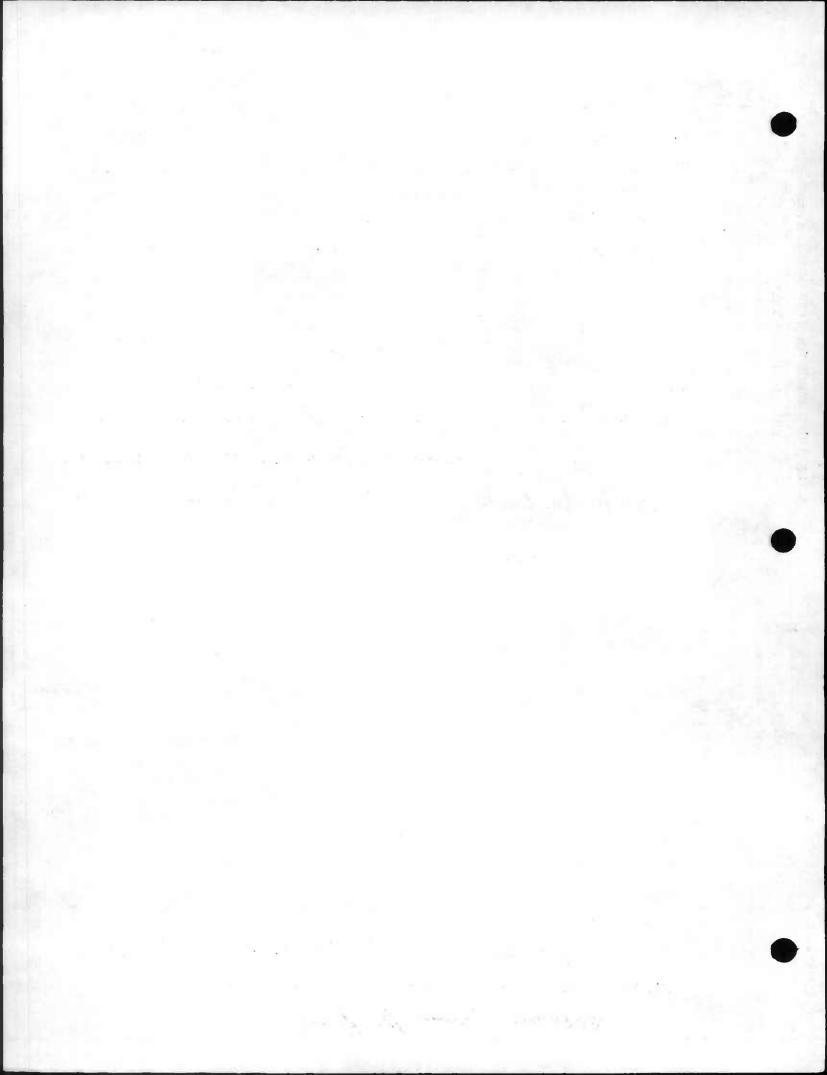
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 28, Day **Physician** Ellen Bomberg Virginia Louise 1999 10:15 pm /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 203 Elk Rd. Baltimore Essex If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV . 20, 1917 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 212 10 6995 1 M 2 X F 81 Director Maryland Usual Residence of Decedent with the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 No Director Maryland Essex 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 Elk Rd. 21221 death Funeral 14. Race - American Indian, Bleck, White, etc. 11 Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Peges 1 and 2 should be filed within 72 hours after nated of Health and Mentel Hyglene.
Intel if item 27 is marked other than "natural; or flee into or other traumate svant, me Medical Emmine.
Into or other traumate svant, me Medical Emmine. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Merried 25 Merried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Milton Gartside Hilda Schindler To 19e. informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Jim Bomberg (Son) 216 Helena Rd. Baltimore, Md. 21221 20a. Method of Disposition 20b. Place of Disposition (Name of Data 20c. Location - City or Town, Stete cemetery, crematory or other place) 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from State permit. Pege Department of Important: If any injury or page. Gardens Of Faith Cemetery 5/1/1999 Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 21. Signature of Funerat Service Licensee 1407 Old Eastern Avenue Essex, Md. 21221 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each lina. Approximeta Intarval Between Onset and Death Physician Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Entar Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai the Due to (or es e consequence of) Se esn Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detact 1 Yes 2 70 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 2 0 No certificate 1□ Yes 1 ☐ Yes 2 ☐ No of Vitai To the Hospital or Attending Physician: " within 24 hours after death. To the Funeral Director: After this certifica 25. Wes case referred to medicat 26. Place of Death (Check only one) Other: 4 □ Nursing Home 5 ☑ Residence 6 □ Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To funeral 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 Yes 2 No 2 Accidant 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner stated. 29a. Certifier Medicai (Check only one) 29b. Signature end titla of 29c. License number 29d. Date signed (Month, Day, Year) 20390 99 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) Dr. Charles Hoesch, 9712 Belair Road, Baltimore, Maryland 21236 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 3 0 1999

AHS



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Physic /Medi		Decedant's Nan Agn	es F. B							2. Date of to Month April	Day		ima of Death	
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Funeral Director		5. Social Security 1 215 07 41	Number	6. Sex 1 □ M 2KJ F		(In yrs. last birthday) If Under 1 Yaar If Under 24 Hours North Days Hours N			Hrs. 8. Date of E			(State or Foreign		
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at be no	ai Dire	10e. Street and Nu 31 Weber			10f. Zip Code 21221						10g. Citizen of USA	What Country?		
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		De la	W 4	Q	la		Bruzo	lzins	ki Fune	eral Home Avenue	P.A.	A 2122	11	
	Physician/Medical Examiner	Immediate Cause disease or condition rasulting in death) Sequentially list or if any, laeding to in cause. Enter Under Cause (Disease or that initiated event rasulting in death)	onditions, nmediate erlying Injury	a. <u>PANC</u>	[Due to (or as a co	onsequence of):						
	sician	Part II. Other signi	d						23b. Did tobacco use contribute to the cause of					
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	Completed by										as en autopsy formed?	availab	outopsy findings le prior to stion of causa h?	
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	To Be	25. Wes case rafar axaminar? 1 ☐ Yas 2 ☑		Hospital:	Inpatier	nt 2 ER/Out	patient 3 0	Ot Ott	200	Death (Check only		ne (Canaita) F	IOCDICE	
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	Sertifik	3 Suicide 4 Homicida Could not be determined 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)							28f. Location City or 7	(Street and Numi own, State)	ber or Rurel Ro	ute Number,		
	edicai	29a. Certifier (Check only one)	1 Certifying 2 Medical E	xaminer: On tha b	a best of besis of a nner stal	axamination and	deeth occurred for investigation	d at the ti	ma, date and pl opinion, deeth o	ace, and due to the	a causa(s) and ma a, data and place,	annar as stated and due to the	l. cause(s)	
	×	29b. Signetura end (itla of certifier) 29c. License number D 4 3 7 25									29d. Data signa	3019		
	-	30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)										-	1	
Sta			RIQ MAH	MOOD 230	00 D	ULANEY V				UM, MD 2	1093			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month 28 erre erville **Physician** 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Deat Facility Nama (If not institution, give street end nu Examiner more Balt, If Undar 24 Hrs if Under 1 Yaar 5. Sociel Security Number 8. Date of Birth (Month, Day, 7. Aga (In yrs. lest birthday) Birthplece (State or Foreign **Funeral** 212-48-4284 Usuel Residence of Decedent Months Deys Hours 10 M 2 F Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haelth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumstic event, the Medical Examiner must be notified at once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland 1 Yas 2 No more Directo 10e. Street end Numbe 10f. Zip Code 10g. Citizen of Whet Country? 2 635 11. Marital Status by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Detas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece -American Indian. Black, Whita, etc. 1 Naver Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: African 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. pDO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Elementary/Secondary (0-12) College (1-4or 5+) echanic 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme Be rainia 19b. Mailing Address (Street end Number of lle 20b. Plece of Disposition (Neme of cematery, cremetory or other 20a. Method of Disposition 1 Burial 2 Cremation 3 Ramovel from State 4 Donetion 5 Other (Specify) 22. Name and Address of Fecility
JOSEPH L. RU
2222 W. North 21. Signethio of Funeral Service Ligenses ne the display, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, beart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Cere brovas unla Accident /Medical Immediate Cause (Fine) disease or condition resulting in deeth) Examiner Examiner elebrov AsculAR diseAse years attending physician and for use es the bunel-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated avents rasulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical Due to (or as a consaquence of): signed by the a Pert ii. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? pentic cata has b 1 Yes certificata To the Hospital or Attending Physician: funaral director, 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA Certification: To After this 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Neturel 2 Accident 5 Pending 1 Yes 2 No 24 hours after death.

Funeral Director: Af investigation Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicida 28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29a. Certifier Medicai (Check only one) within 2 29b. Signeture end title of certifiar 29d. Dete signed (Month, Dey, Year) 28,1999 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Baltimere

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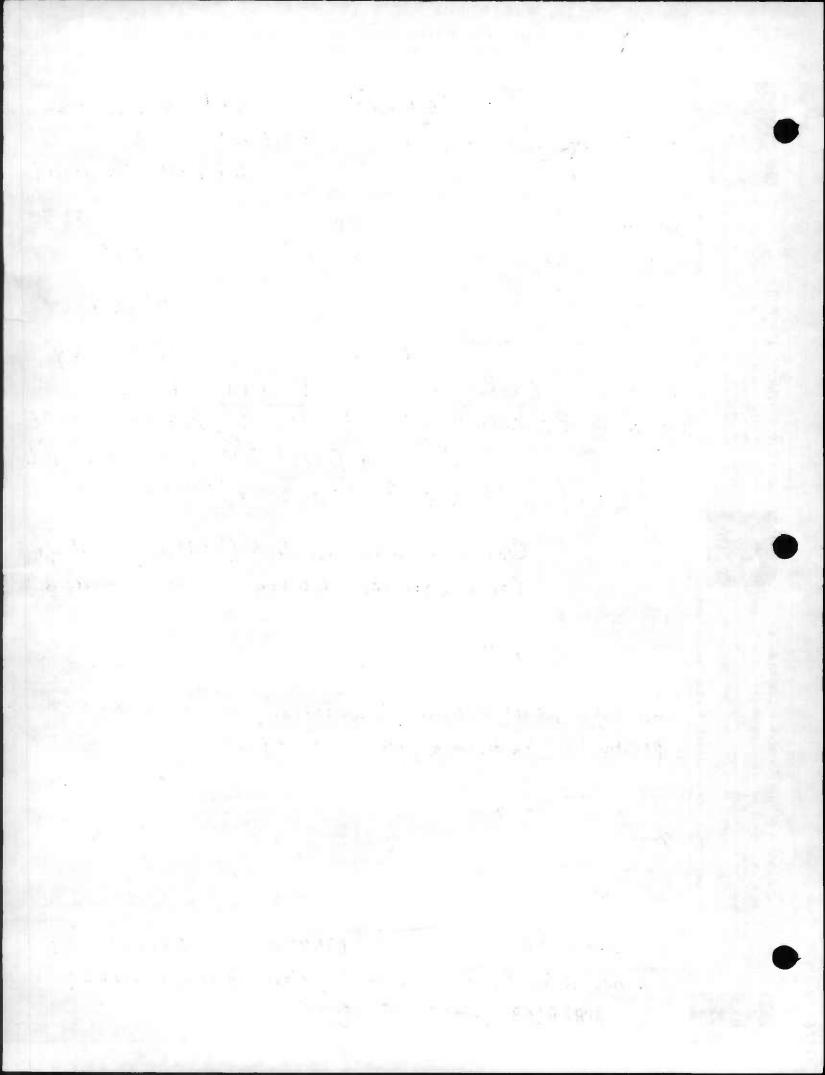
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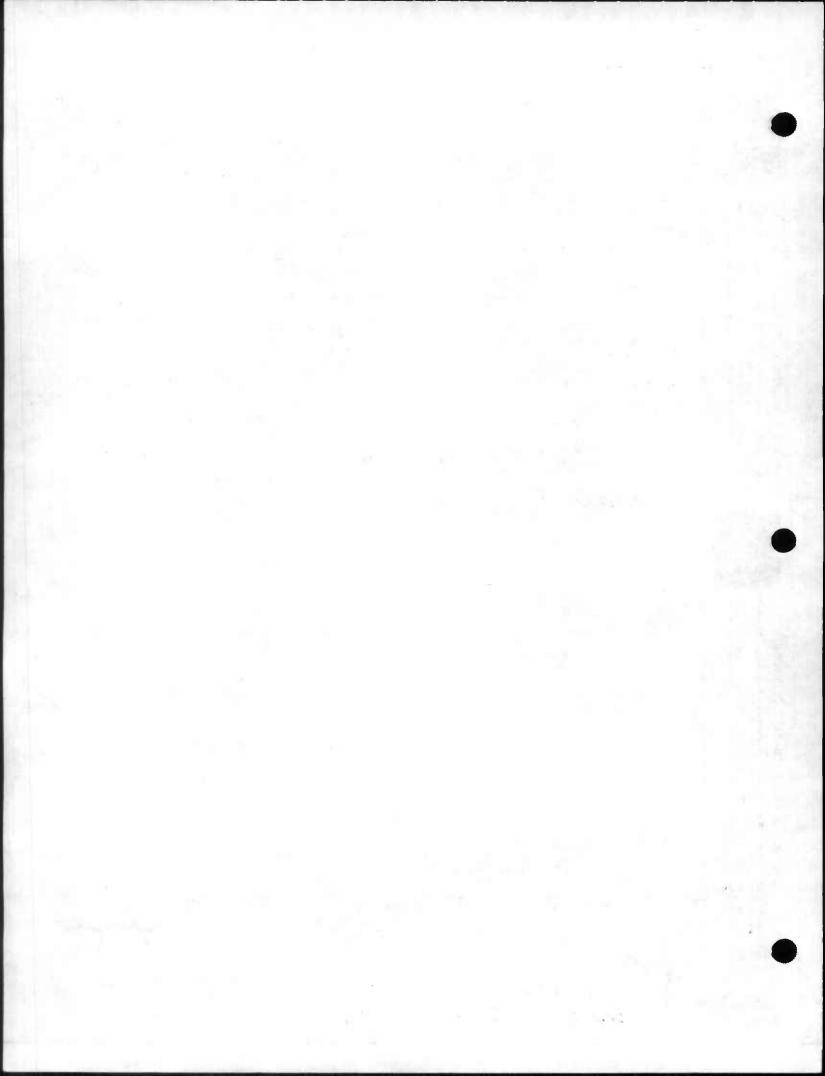
31. Date filed (Month, Day, Year)



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B Suicide 6 Could not be determined	280. Piece of injury -	At home, ferm, stripecify)	reet, factory, office				ber or Rural F	Poute Number,
Certifier (Check only one) 1 Certifying Physical Example (Check only one)	niner: On the basis of exa	y knowledge, deeth minetion and/or inv	n occurred at the ti vestigation, in my	ime, date and place, opinion, deeth occur	and due to the red at the time,	cause(s) and ma date and plece,	anner as stet and due to th	.ed. he cause(s)
Signature end title of certifier	A .	N	29c. Licen	se number		29d. Date signe	d (Month, Da	sy, Year)
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lame and address of person who	completed cause of death	(Item 23a) (Type,	Print)					03004
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		R: Certificate		Reg. No.		6	U	1-3	6.

Physician
/Medical
Evaminer

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760.

	1. Decedent's Nam	ma (First, Middle, I	Last)								2. Date of Month		g. No.	Yaar	3. Time o	Death
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4	ta Facility Name	(If not institution, g	jive street a	nd number	r)				4b. City,	, Town, or	Location of De	eath	4c. County	y of Deat	h	
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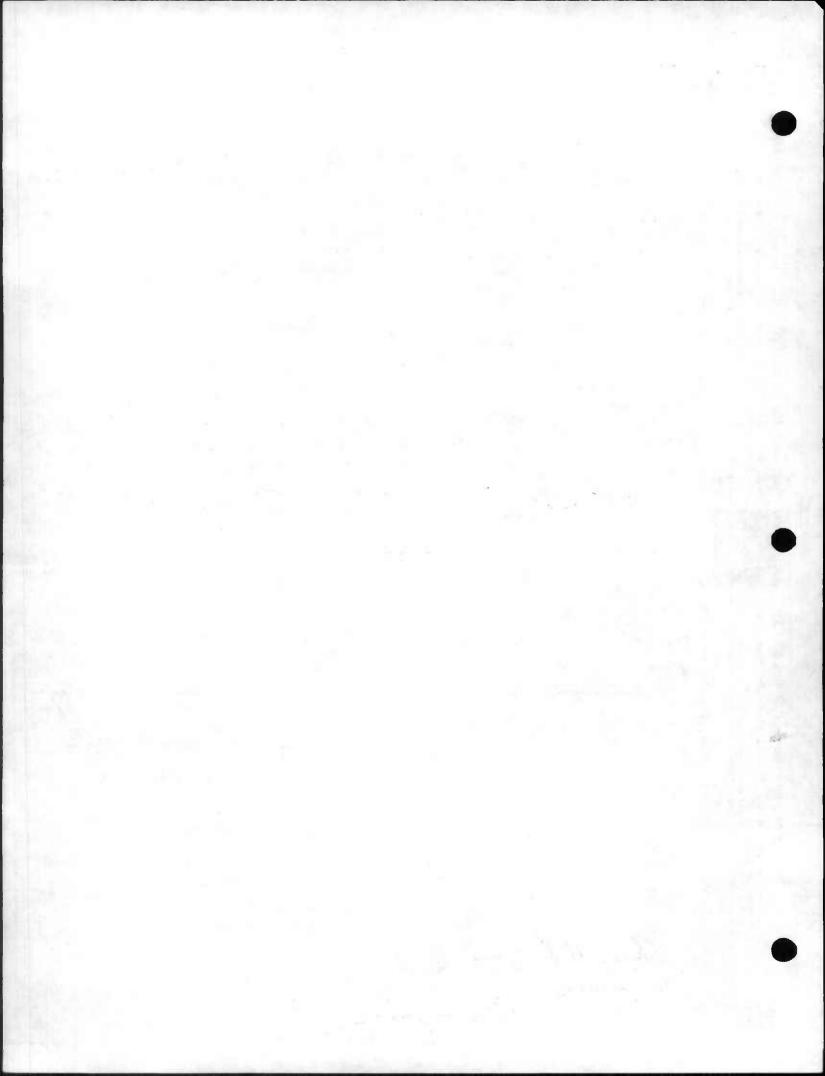
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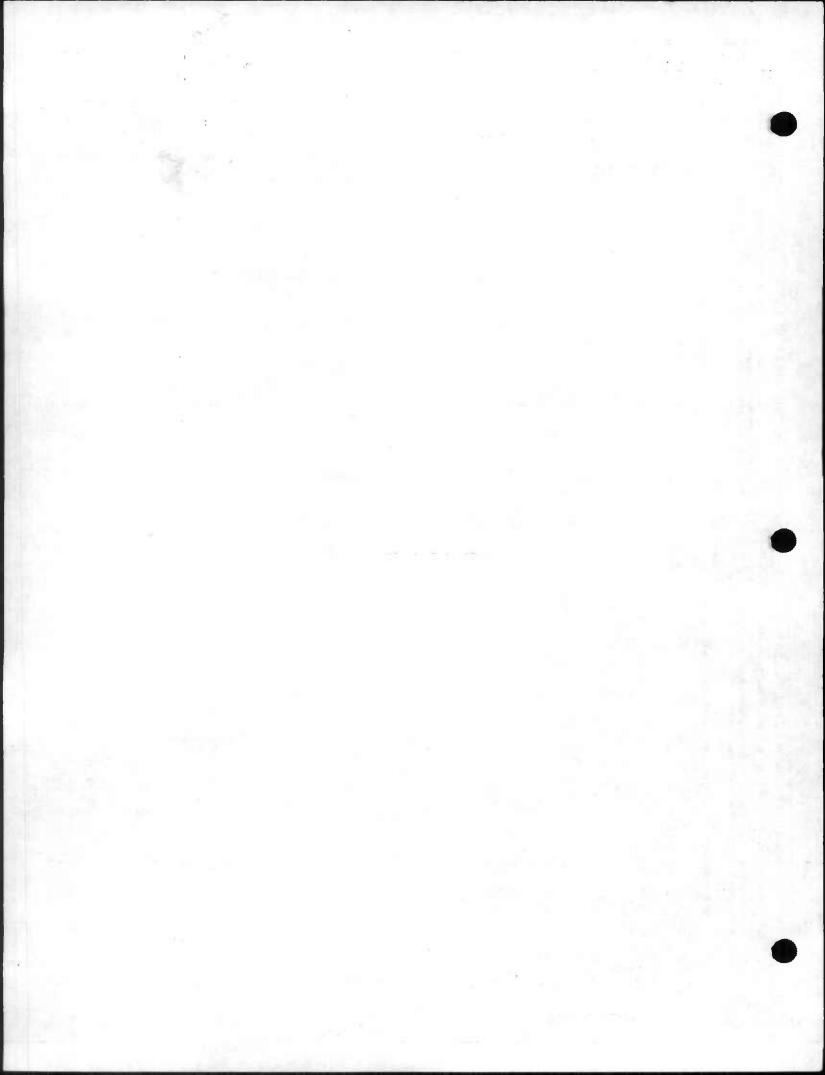
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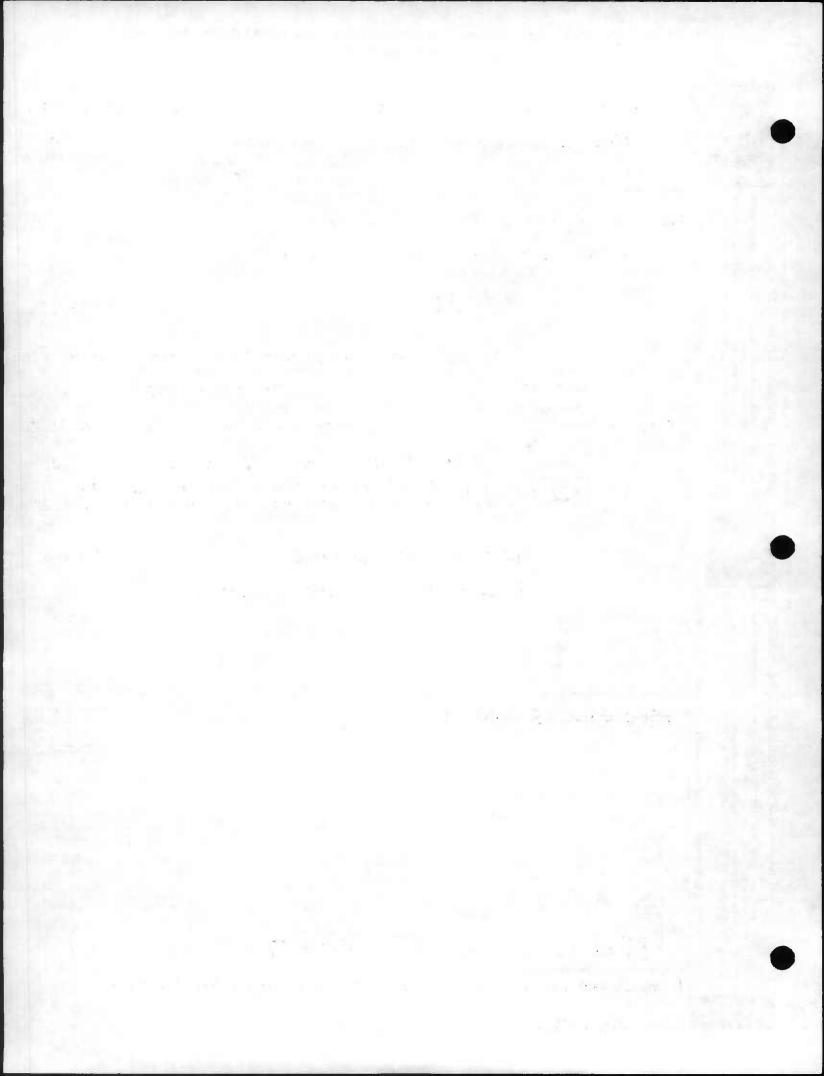
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	1. Decedent's Neme (First, Middle, La	ist)		Certificate of		2. Date of Dea	eg. No.	3. 1	Time of Deeth
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Je L	11. Marital Status	12. Wes Decedent E Armed Forces?		13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp	pecify Yes or No-		e - American Inc	dien,
b F	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	1. Yes 2 N If Yes, Give Year or Detes:	1957- 1959	1 ☐ Yes 2√ No		Hicen, etc.)	Specify	White, etc.	e
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iclan	shock, or heart feilure. List only	one cause on eech lin	е.					Onse	vel Between et end Death
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	30. Name and addrass of person who				BALTIMO	OF MAD	2120	1	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEM: #19A PER INFORMANT G772 G7 State of Maryland / Department of Health and Mental Hygiene ITEM: #23 PART I PER MD G772 6-15-99 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3 Time of Deeth Day **Physician** Martha Beirponch 1999 April 28. 11:10 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Hebrew Home of Greater Washington Rockville Montromery If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 13 1 Birthplace (State or Foreign Country) **Funeral** 1□ M XX F Months Days Hours 040-40-0543 87 Sept. Director Poland Usual Residence of Decedent tha Maryland 10e Stete 10b. County 10c. City. Town or Location r than "naturel", or itams 23a or 28a-f show the Modical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6121 Montrose Road 20852 USA Funeral or itams 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Raca - American Indian. Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White py 3 ☐ Widowed ★ X Divorced Yeer or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) 12 Various Firms Executive Secretary Pages 1 and 2 should be filed valent of Haalth and Mental Hygia int. If tem 27 is markad other 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David Freedman Bessie Steinberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Lepartment of Haalth an Important II from 27 is n Carla Kleyan/Daughter 8711 Brierly Court, Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from State 4/30/99 Olney, MD Judean Memorial Gardens 4 Donation 5 Other (Specify) Service Ucensee 22. Name and Address of Facility Takoma Funeral Home 254 Carroll Street NW, Washington, DC shock of higher failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Physician tro cardinenula, diser /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner OSTEOPOROSIS law requires that the death certificate be executed physician and s tha bunal-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequença of): P.O. Box 68760. PERIPHERAL NEUROPATHY Physician/Medical Due to (or as e consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records. þ eted 24b. Were autopsy findings eveileble prior to completion of cause 24a. Was an autopsy performed? B this funeral Aftar

or Attending s after dec. 24 hours aftar Eunerei Dire lataly fillad In b

			υ	U		1 ☐ Yes 2 D No	1 ☐ Yes 2 ☐ No
25. Was case reference examiner?					26. Place of D	eath (Check only one)	
1 ☐ Yes 2 ☐	No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpetient 3[Home 5 ☐ Residenca 6 ☐ Other	(Specify)		
27. Manner of Death 1 ☑ Naturel 2 ☐ Accident	n 5 □ Pending Investigetion	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury		c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurre	d
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		home, farm, street, facify)	actory,	offica	28f. Location (Street and Numbe City or Town, State)	r or Rural Route Number
29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	ysician: To the best of my kr niner: On the basis of examinand menner stated.	nowledge, deeth occur nation and/or Investig	rred at ation, in	the time, dete end place in my opinion, death occ	ce, and due to the cause(s) end man curred at the time, date and placa, ar	ner as stated. nd due to the cause(s)

29b. Signature and title of certified

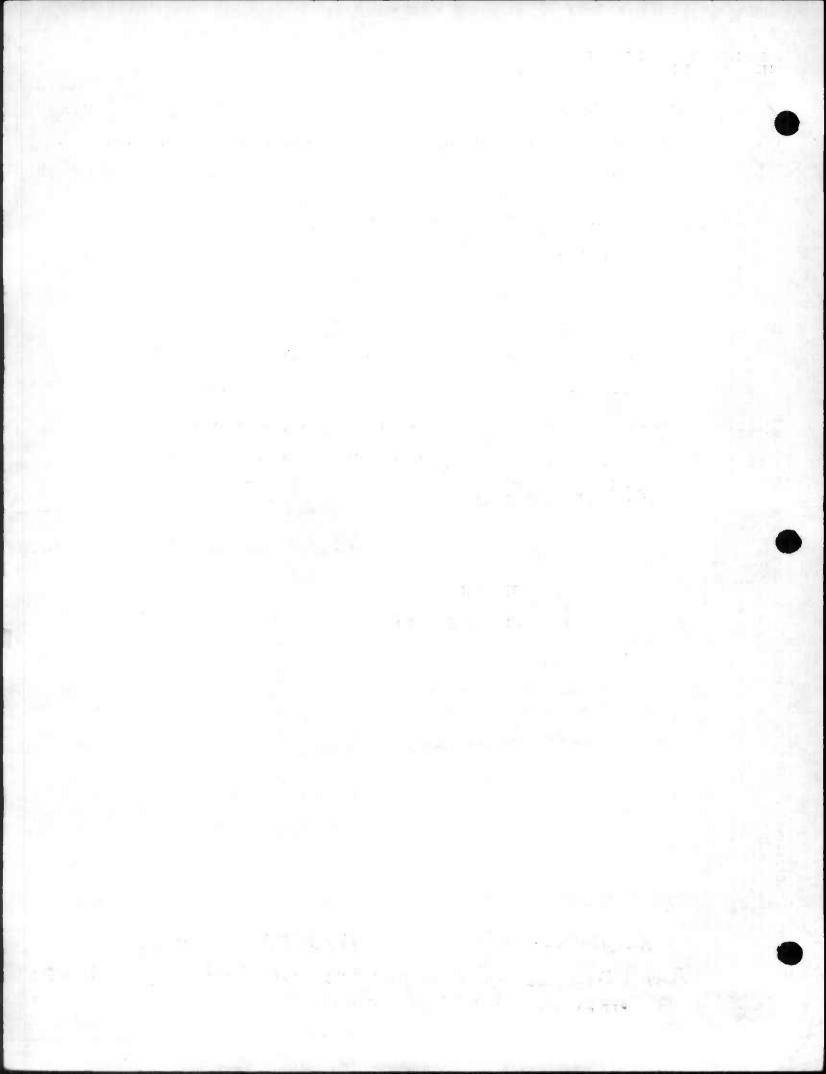
29d. Date signed (Month, Day, Year) 23958

30 Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Sury J-Fushmen MD, 6105 Mb/ 6105 montroze lel., Rozdeni/le

State Registrar

within 24 hor To the Fune complataly fi



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended#1 perPhy G770 4/30/99 EW 3. Tima of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death Ronald Norman Bartell FEBRUARY 22 **Physician** 1999 ponald Bartel 01:55AM Norman /Medical 4b. City, Town, or Location of Deeth 4a Fecility Nama (If not Institution, giva straat and number) 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** Months Days Hours 12 M 2 F 384-30-8719 Yrs. Oct. 7, 1933 Michigan 65 Director Usual Rasidance of Decedant with the Maryland 10a. Stata 10b. Counts 10c. City. Town or Location 10d. Insida City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Modical Examiner must be notified at 1 Yes 2000 Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whal Country? 21015 USA pemit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumstic event, the Modical Examiner mans) once. 1207 Mazeland Dr. Funerai 12. Was Decedani Ever in U,S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Bace - American Indian 11. Marital Status Bleck, White, atc. 1 Navar Marriad 2 Married 1 as 2 No If Yas, Give Korean Yaar or Datas: altimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Spacify: White þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elementery/Secondary (0-12) Coltege (1-4or 5+) Financial Officer Steel Industry 4 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Felher's Nama (First, Middle, Last) Norman Robert Bartell Cora Grace Childs 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ratationship (Type, Print) Joan L. Bartell/ Wife 1207 Mazeland Dr. , Bel Air, MD 21015 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 2-26-99 Akron. Ohio 4 ☐ Donation 5 ☐ Other (Spepily) Rose Hill Cemetery 22. Nama and Address of Facility
HOWard K. McComas III Funeral Home, P.A. 24- Stonayure of Funeral Service/L 1317 Cokesbury Road, Abingdon, Maryland 21009 Enter the diseat or heart failure. Approximata Intarval Between Onsat and Death ath. Do not antar tha mode of dying, such es cardiac or respiratory errest, me ceuse on each line. **Physician** /Medical Immediata Cause (Finel disaese or condition rasulting in death) Bronchial 20 MIN Examiner Dua to (or as a consequence of) Examiner attending physician and for use as the burial-trensit that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or es a consaguança of): P.O. Box 68760. Physician/Medicai Dua to (or as a consequanca of): use as f signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Division of Vital Records, ð 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed complation of causa of death? pege 2 s has 2 NO 1 ☐ Yas 1 ☐ Yes 2 ☐ No certificate or Attanding Physician: director. 25. Was case refarred to medical axaminar? 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No P Inpatiant 2 ER/Outpatient 3 DOA this 28a. Dala of Injury (Month, Day Year) funeral 27. Mannar of Deeth 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After 1 Natural
2 Accident 5 Panding invastigation 1 ☐ Yes 2 ☐ No 24 hours after death. 6 Could not be datarminad 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streal, factory, office building, atc. (Spacify) 3 ☐ Suicida 4 Homicida Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es sletad.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) To the F within 2 29b. Signatura and titla of certifian 29d. Data signed (Month, Dey, Year) Undree MD February

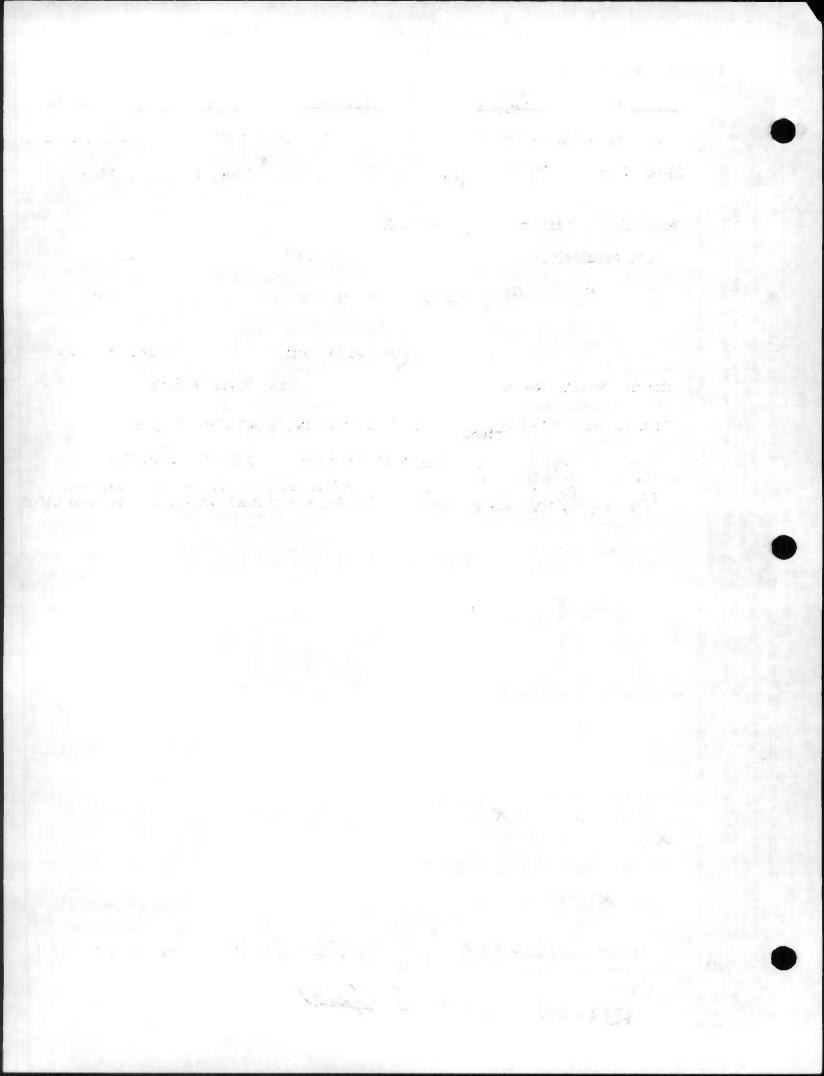
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Registrar

Johns 32. Registrar's Signatura

30. Nama end eddrass of person who complated causa of daeth (Item 23a) (Type, Print)

31. Data filad (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEMS: #12 PER F.H. G771 5-11-99 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth George Albert Breder 009M 4c. County of Deeth of Deeth 4a Fecility Neme (If not institution, give street end number) 4b, City, Town, or Location OSec HOSPita if Under 1 Year Timore tranklin 9 yeare If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey. 7. Age (In yrs. lest birthday) 5. Social Security Number Birthplece (State or Foreign Country) 1 XM 2 ☐ F Months Deys 67 202-22-6396 Sept. 4,1931 Pennsylvania Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 No Anne Arundel Odenton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1460 Berger Street, PO Box 171 21113 USA 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Bleck, White, etc. 1 XYes 2 No 1949-If Yes, Give Yeer or Detes: 1967-70 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☑ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Inspector State of Maryland 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Albert Ernest Breder Marion Stackhouse 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Connie R. Alascio (Friend) PO Box 520, Odenton, MD 21113 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Maryland Veterans Cem. 05/03 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD 22. Name end Address of Fecility Hardesty Funeral Home, P.A 21. Signature of Funeral Service Licenses 12 Ridgely Avenue, Annapolis, MD 21401 cleste Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth immediate Ceuse (Final disease or condition resulting in deeth) PSIS Due to (or as e consequence of): eymogra Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? bstructive Pulmonary 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? completion of cause of deeth?

Physician /Medical Examiner

Important: If It

Depertment

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Funeral

Director

7 is marked other than "naturel", or items 23a or 28a-f shot traumetic event, the Modical Examiner must be notified at

72 hours efter deeth with the Marylend

Peges 1 and 2 should be filed within nent of Health end Mentel Hygiene.

Examiner physician end s the buriel-transit Physician/Medical signed by the a þ Completed irector, page 2 s Be Certification: To

The lew requires that the death certificate be executed

Hospital or Attending Physician:

To the Hospital or Atterwithin 24 hours after decouple to the Funeral Director completely filled in by the

Division of Vital Records, P.O. Box 68760,

funeral director. this After I Director: Aff

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

Persistent Neuro-Vegetative

State

25. Wes cese referred to medicel exeminer? 1 Yes 2 No

27. Manner of Deeth 1 Naturel 5 Pending investigation 2 Accident

3 Suicide 6 Could not be determined 4 Homicide

Hospital: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work?

1 🗌 Yes 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

2 No 1 Yes 1 ☐ Yes 2 ☐ No

26. Plece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted. 29c. License number

29b. Signature end title of certifier m.0

00051356

2 No

Drive Baltimore

29d. Dete signed (Month, Dev. Year)

30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print)

Dr. Michael Picco 31. Dete filed (Month, Day, Year) APR 3 0 1999

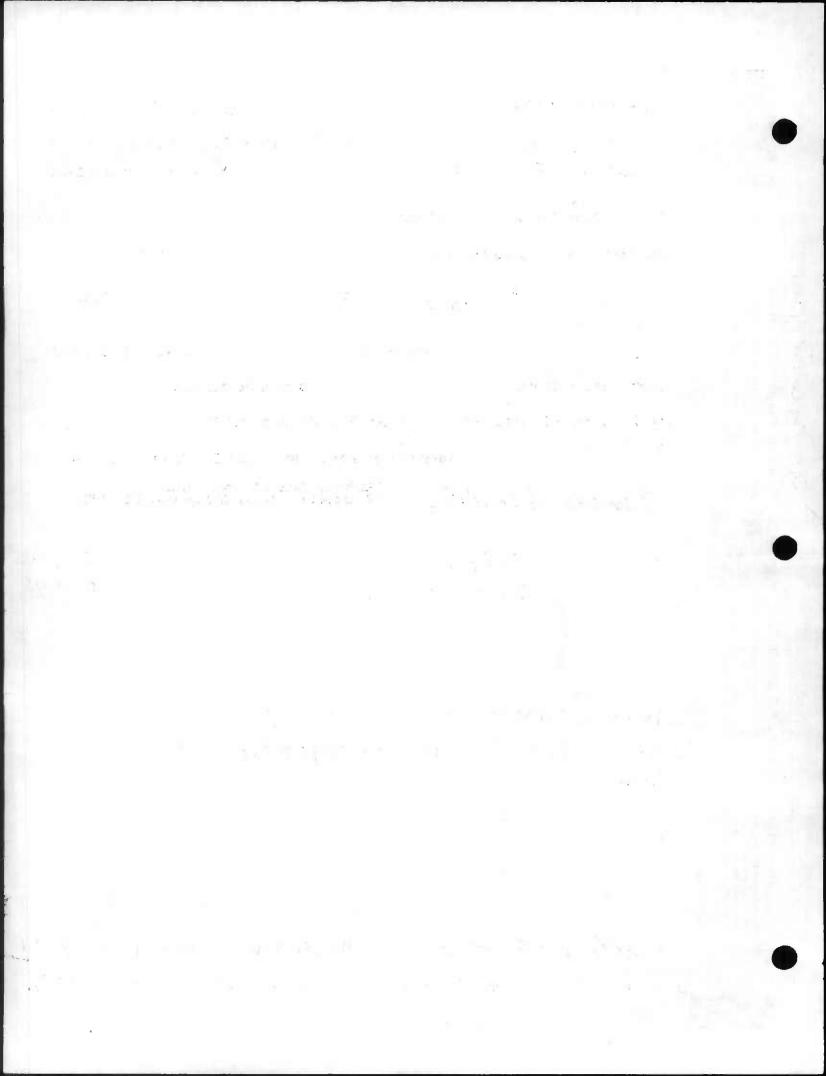
9000 Franklin 32. Registrer's Signeture

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State Registrar

Medical

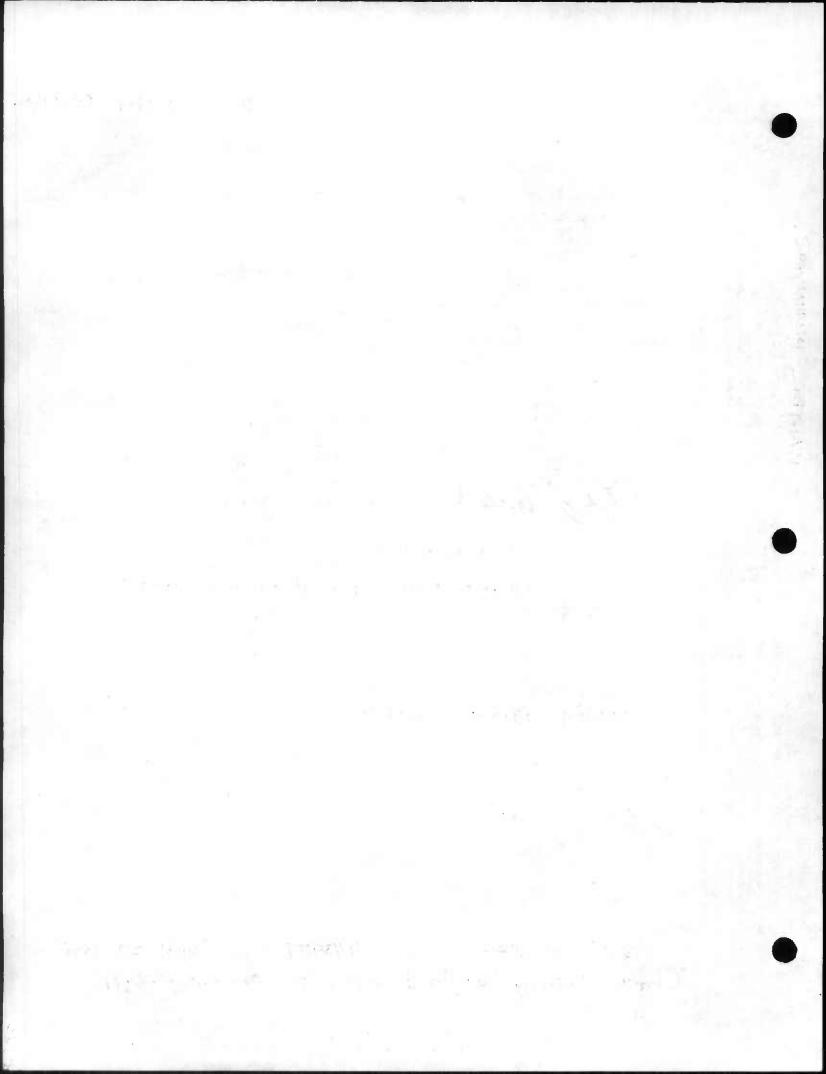
29a, Certifier (Check only one)



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State of Maryland / Department of Health and Mental Hygiene

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by Funeral Director	Usual Residence of 10a. Stete	10b. County		10c. City, To	own or Location	1				1	10d. tnside City Limits
ctor	MD	Anne Aru	undel	0den	ton						1 ☐ Yes 2 TNo
rai Director	10e. Street and Nur 533 Rit	mber ca Drive				f. Zip Code 211			10g. Citizen of V USA	Vhat Cou	ntry?
by Funeral	11. Meritel Stetus 1 Never Marri 3 Widowed	ied 2 Merried 4 Divorced	12. Was Decedent Armed Forces? IVX es 2 1 If Yes, Give Yeer or Dates:	No	1□¥	Decedent of specify Cut es 20 No	Hispanic Origin? (Sean, Mexican, Puerl Specify:	Specify Yes or No to Rican, etc.)	Specify	k, White,	can Indien, etc. nite
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been signed by the attending physician and should be detached for use as the burial-transit leted by Physician/Medical Examiner	Sequentially list co if eny, leading to in cause. Enter Unde Ceuse (Disease or that initiated events resulting in death) I	inditions, nmediete srlying Injury s Lest	b. Clarom	C D Due to (or es	e consequence a consequence	OWE on:	- Arem	ONAM	DREAD	٤	
Physician/Me			d							1	
hysi	Pert II. Other signif	Control Conditions co	contributing to death but not resulting in the underlying				ven in Pert I.		tobacco use cor Yes 2□ No	ntribute 1	o the cause of death?
by		WHOM	AIGE	[DI	CEASE	•		04-14/04		24b W	ere eutopsy findings
Completed								perf	en eutopsy ormed?	6/	veilable prior to ompletion of cause death?
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Be	25. Wes case reference examiner?		Hospital:			_ 0	hor	eth (Check only	111		
tion: To	27. Manufar of Death	NO	28e. Dete of Inju	ry 281	Outpatient 3[o. Time of Injury	28c. Inju	4 LI Nursing F	1	idence 8 Oth how injury occur		fy)
Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	28e. Plece of Inj building, etc	ury - At home c. (Specify)	, farm, street, fe		A-1	28f. Location City or To	Street and Numb wn, State)	er or Rur	al Route Number,
Medical Certification: To Be (29a. Certifier (Check only one)	Certifying Phy	reictan: To the best of iner: On the besis of and menner ste	examinetion	lge, death occu end/or investig	rred et the t etion, in my	ime, date and place opinion, deeth occu	e, and due to the urred et the time,	cause(s) end me date end place,	enner es s end due t	stated. o the cause(s)
Me	29b. Signeture end	title of certifier				29c. Licen	se number		29d. Date signe	d (Month,	Day, Year)
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State gistrar	30. Name end eddre 31. Dete filed (Mont	th, Day, Year)	ompleted cause of d		pipul B	nve,	Oflen !	Bunnie	no.2	1061	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Deeth 1. Decedent'e Neme (First, Middle, Last) Month 20 SPATE Apri ne 4b. City, Town, or Location of Death 4c. County of Deeth ility Neme (If not institution, give street end number) 'more HOPKINS alt JOHNS 9 Under 24 Hrs. 6. Sax 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (Steta or Foraign Country) 5. Sociel Security Number 216-16-9421 Deys Months Hours 1 M 2 F Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10a. Stata 10d. inside City Limits BALTO 1 Yas 2 No MI 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 122 413 (WOOD TUE 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puarto Rican, etc.) 14 Bace - American Indian Black, Whita, atc. 1 Yas 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marriad 1 Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) Home HomemAKER 10 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fathar's Neme (First, Middle, Last) BERTHA SABAU ETER STANIFWICZ 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 413.5. AUE., BALTO., MD 2/3 Date 20c. Location - City or Town, Stata CEWIS E. BRADFORD 20e. Method of Disposition MD 21227 ELLWOOD 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete GARRISON FOREST YA Com 4-29-19 OWINGS MILLS 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Address of Fecility KACZORO WSK! 21. Signature of Funaral Sarvice Licensee 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory errest, shock, or heart feilure. List only one cause on each line. BALTO 21222 Approximete Interval Between Onset and Daeth Immediate Ceuse (Final disease or condition resulting in death) 1040 intra erania Due to (or es e consequence of): coaquation Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted avents resulting in death) Last Due to (or-as e consequence of): arter Dua to (or as a consaquance of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24e. Was en eutopsy performed? completion of ceuse of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpetient 3 DOA

Physician /Medical Examiner

Important: If he any Injury or c

Physician

/Medical

Examiner

Director

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Funeral

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Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural," or Items 23s or 28s-1 show

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7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a

Examiner physician and the burial-transit 68 use certificate has b lirector, page 2 s

requires that the death certificate be executed

Hospital or Attending Physician:

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After

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24 hours e

To the Hosp within 24 hor To the Fune completely fi

filled in by

Medical

Division of Vital Records, P.O. Box 68760,

funeral director.

Physician/Medical þ Completed Be Certification: To

25. Wes cese referred to medical examiner? 1 Yes 2NNo 27. Manner of Death

1 Neturel
2 Accident 5 Pending investigation 3 Suicida 6 Could not ba 4 - Homicide

28e. Date of Injury (Month, Dey Yeer) 28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

 Location (Street end Number or Rurel Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, dete end plece, end due to the ceuse(s) end menner es steled.

2 Medical Examinar: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated.

(Check only one) 29b. Signature and titla of certifian

29a. Certifier

29c. Licansa number

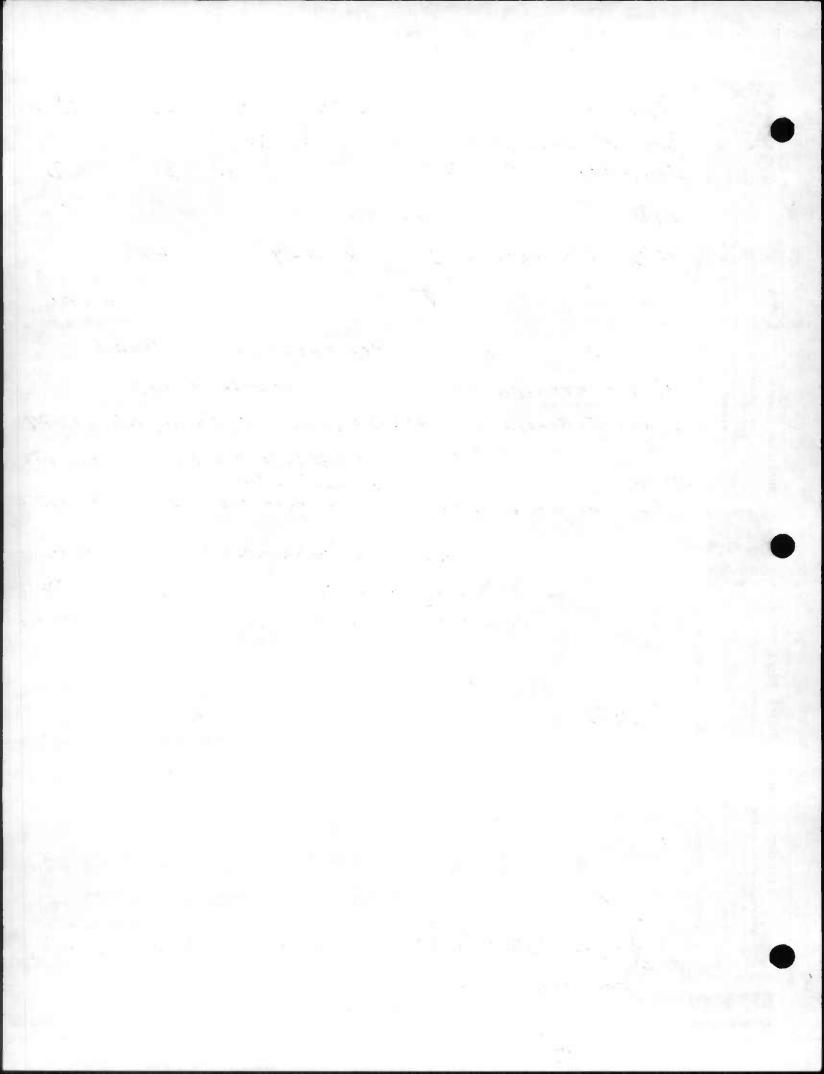
29d. Data signed (Month, Day, Year)

address of person who completed cause of deeth (Item 23e) (Type, Print)

31. Dete filed (Month, Dey, Year) Pbesu

32. Registrer's Signeture

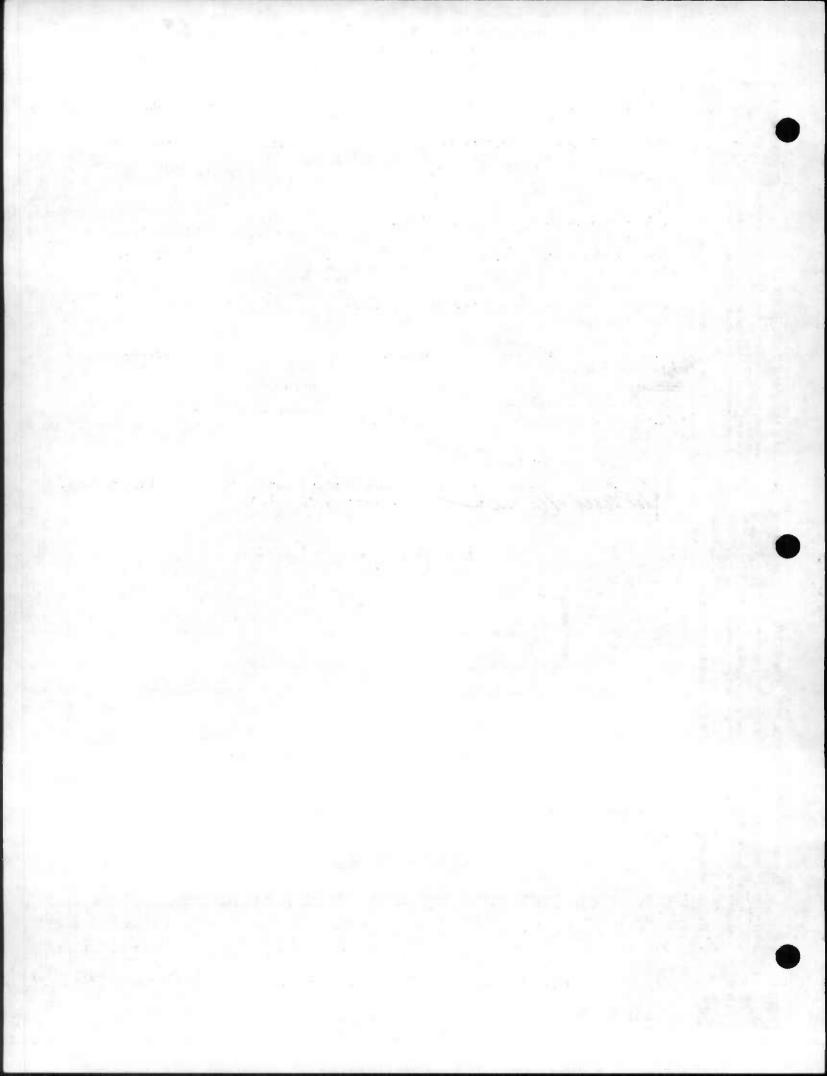
State Registrar **DHMH 16 Rev 6/95**



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Deta of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth Month **Physician** 1999 March 1, 4:15 PM Patricia Bell ' /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner Eastpoint Rehab and Nursing Center Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
Months Deys Hours Min. (Month, Dey, Year)
May 31, 1925 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 2☑ F Months Deys Yrs. Maryland 73 Director 219-22-8373 Usuel Residence of Decedent the Marylend r 28a-f show 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or itams 23a or traumatic event, the Medical Examinal must be a 1046 Old North Point Road 21222 U.S.A. Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Dacedant Evar in U,S. Armed Forces? 13. Wes Decedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer. Department of Health and Mantal Hygiona. Important: If Itam 27 is marked other than "natural", or ita, any injury or other treumatic event, the Medical Examina 1 Yes 2 No
If Yas, Giva
Year or Dates: unknown 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white þ 3 ₩ Widowed 4 Divorced unknown Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast greda complated) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surneme) unknown unknown 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) unknown 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specifyin state Ronald S. Wade Director 22. Nama end Addrass of Fecility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 23a. Pel L. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errast, shock, or heart feilure. List only one ceuse on each line. Approximata intervel Between Onset end Death **Physician** Esophayeal Cancer /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner physician end the burial-transit Sequentielly list conditions, if eny, leeding to immadiate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of): Box 68760, Physician/Medical Due to (or es e consequence of): USB signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably Monknown Division of Vital Records, by 24b. Wara autopsy findings eveileble prior to completion of cause of deeth? should Completed 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? Be 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 200 No After this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: il or Attending P s after death. 1 Watural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examinar: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signetura and title of certifier 29c. Licensa number 4/2/199 D43725 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) Erdman Ave Baltimore MD 21213 3400 MAHMOUD IARIQ 31. Date filed (Month, Day, Year) 32. Registrer's Signature State APR 3 0 1999 Registrar



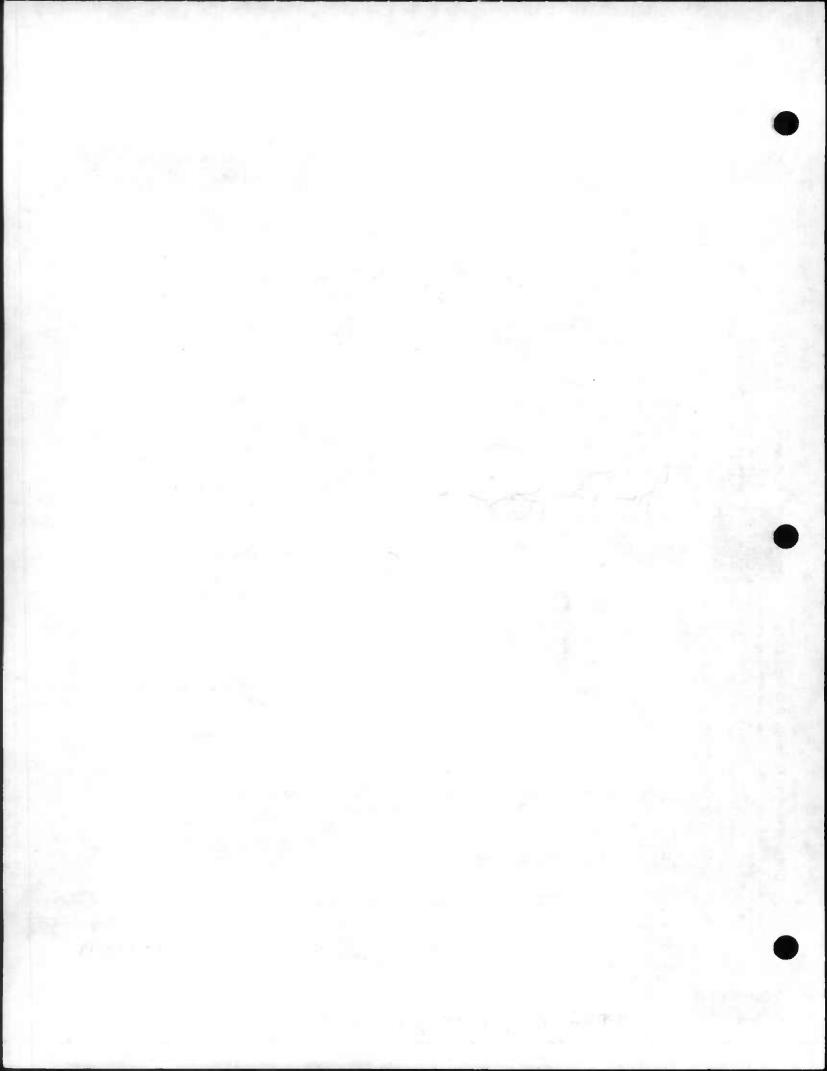
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State of Maryland / Department of Health and Mental Hygiene

				Certifica	ate of	Death		Reg. No.	1	001		
Physician	Decedent's Name (First, Middle, Tagels						2. Date of D Mooth April	26, Dey 1999		3. Time of Death		
/Medical	Jack	Culper	per			4h Cihi Taum	April , or Location of Dea			9:13 am		
Examiner	4a Facility Name (If not institution, 209 Hollywood Co					Glen B			Aruno	ile		
Funeral Director	252-32-3118	Sex 7. Age (I	In yrs. lest bir 69	Yrs. If Unc Month	er 1 Year s Days		Hrs. 8. Date of Bi Min. (Month, D Oct. 0	ay, Year)	9. Birthpled Country Georg	ce (Stete or Foreign)) La		
S	Usuat Residence of Decedent 10s. Stale 10b. County	10	Oc. City, Tow	n or Location					10d	I. Inside City Limits		
death with the Maryland ms 23a or 28a-f show r.must be notified at neval Director	Maryland Anne Ar	rundle	Glen E	Burnie						1 ☐ Yes 2X No		
or 28s-f.	10e. Street and Number			101.	Zip Code			10g. Citizen of	Whal Country	/?		
23a o Mariba	209 Hollywood Co	ourt		2	1061			U.S.A.				
020 un sher ar, or he Example	3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:				lispanic Origin an, Mexican, P Specify:	? (Specify Yes or N ruerto Rican, etc.)		ce - American ck, White, etc y: White	C.		
Franking Natural Property Prop	15. Decedent's		Decedent's Us	sual Occup	pation	undina	16b. Kind of B	usiness/Indu	stry			
21215-0020 ed within 72 hours at typiene. er then "natural", or t, the Medical Exam Completed by §	(Specify only highest: Elementary/Secondary (0-12)	College (1-4or 5+)	College (1-4or 5+)			d)	Withing	4				
Cor The Cor	6	- 1	Dr	river		40.00.00		Truckir		bany		
Maryland 42 should be file h and Mental Hy lis marked othe traumatic event	17. Fether's Name (First, Middle, La Grover Culpept						Name (First, Middle beth lat		ne)			
T T	19a. Informant's Name/Relationship		19h	. Mailing Adds	ss (Stran		or Rural Route Numi		State 7in C	ode)		
Man of the state o	Nova Culpepper	* * * * * * * * * * * * * * * * * * * *					, Glen Bu					
Te. 1 a. 1	20a. Method of Disposition		20b. Place of	Disposition (N	lame of		Date	-	n - City or Town, Stete			
Saltimore smil. Pages 1. Separtment of He mportant: if then ny Injury or oth filits.	1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	Removal from State		ns Of F		Ce)	4/28/99	Baltimo	ore, Ma	aryland		
Se yield	21. Spreture of Fundan Service Lie	ensee		22. Name	and Addre	ess of Facility			•			
00 88558	21. Shanne of Function Service Ucensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21											
	23a Parti Enter the disease, or co	mole ations that caused the	e death. Do r	not enter the m	ode of dyi	ng, such as ce	rdiac or respiretory	arrest,	, A	opproximete ntervel Between		
Physician	The state of the s								C	Onset end Death		
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a	Met	ryther		Lung	Conce		, v	nhon		
MAN 5		Du	e to (or as a	consequence o	0):				1			
68760, titleate be assected in physician end es the burial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	b. Du	e to (or es a d	consequence o	f):							
5 P. S	that initiated events resulting in death) Last	Due d	e to (or as a c	consequence o):							
death death of tor	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.							tobacco use co	entributa to ti	he cause of death?		
Physical Phy		art ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.							3 Probe	bly 4 Unknow		
, the sea of									1			
II HECORDS, P.O. BOX The law requires that the death ce- tate has been signed by the attendir page 2 should be detached for use Completed by PhysicianA	4 1121 2							s an autopsy ormed?	aveila	e eutopsy findings able prior to pletion of cause eath?		
in: The law liftcate has to or, page 2 a							10	Yes 25No	101	Yes 2□ No		
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는 사람들 는	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2□ ER/Ou		JUA		ng Home 500 Res					
E Property	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat			Time of njury M	28c. Inju Wo 1	ryet rk? Yes 2 ∐No	The second second	how injury occur	rred			
DIVISION of a standing of a st	3 Suicide 6 Could not determine			rm, street, fact	ory, office		28f. Location City or To	(Street end Num wn, Stete)	ber or Rural F	loute Number,		
To the Hoeptal o within 24 hours at To the Funerel Di completely filled in	29a. Certifier 17 Certifying (Check only one) 2 Medical Ex	Physician: To the best of marriner: On the basis of example and manner stated	ny knowledge amination and I.	, death occume d/or investigation	d et the ti	me, date end p opinion, death o	lace, and due to the occurred et the time	cause(s) end m date end piece,	enner es stet end due to ti	ed. he cause(s)		
To the comp	29b. Signature and title of certifier			2	9c. Licens	se number		29d. Date signe	ed (Month, De	ey, Year)		
	> Allmy				Di	10854		4-	27 - 6	49		
	30. Name and address of person who	chera		(Type, Print)	pı	4	>nltime.	MD 2	1202			
State	31. Date filed (Month, Day, Year)	32. Registrar's	Signature		1,1							
Registrar	APR 3 0 1	999 Pener	4	4 1	20. 4	,						

DHMH 16 Rev 6/95

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month **Physician** Carl Camma April 26, 1999 12 Noon /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 101 Center Place Apt. 218 Dundalk Baltimore If Undar 1 Yaar If Undar 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. last birthdey) 8. Data of Birth (Month, Dey, Year) April 20,1901 Birthplece (State or Foreign Country) **Funeral** Deys Min. Hours Months 220-12-5541 XXM 2DF Yrs Director Italy Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Dundalk 1 ☐ Yes 2 No Maryland Baltimore Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 23a or 21222 United States Apt. 218 101 Center Place Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forcas? 'natural', or items 14. Race - Amarican Indian 11 Meritel Status Black, Whita, etc. hours after 1√ Yas 2 No If Yes, Give 1₺ Nevar Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: TIWW þ White 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elamantery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed wit Department of Heelth and Mental hygient important: if item 27 is marked other tha any injury or other traumatic event, that pace. 5 Years Barber Shop Owner Barber 17. Father's Nema (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumeme) Frank Camma Sarah Tortorici -19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Rosalie Donaldson/Niece 3114 Cornwall Road Dundalk, Maryland 21222 20b. Place of Disposition (Neme of cemetary, crematory or othar plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 □ Donetion 3 □ Other (Specify) Entombment Most Holy Redeemer Cem. 4/30/99 Baltimore, Maryland 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the diseese, or complications that causad the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or haart failura. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Ceuse (Final diseese or condition resulting in death) Oronary Examiner Due to (or as e consequence of): Examiner attending physician and for use as the burial-trensit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata ceuse. Entar Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown been signed t Division of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? Peptic Vicer Orsees Completed 24a. Wes en autopsy performed? 1 Yas 2 No 1 Yes 2 No certificate Hospital or Attending Physician: 24 hours after deeth.
Funeral Director: After this certificately filled in by the funerel director. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No edicai Certification: To 28a. Date of fnjury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stata) Place of fnjury - At home, ferm, straat, factory, office building, atc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the bast of my knowledga, daath occurred et the tima, data end plece, end due to the cause(s) and manner as stated.

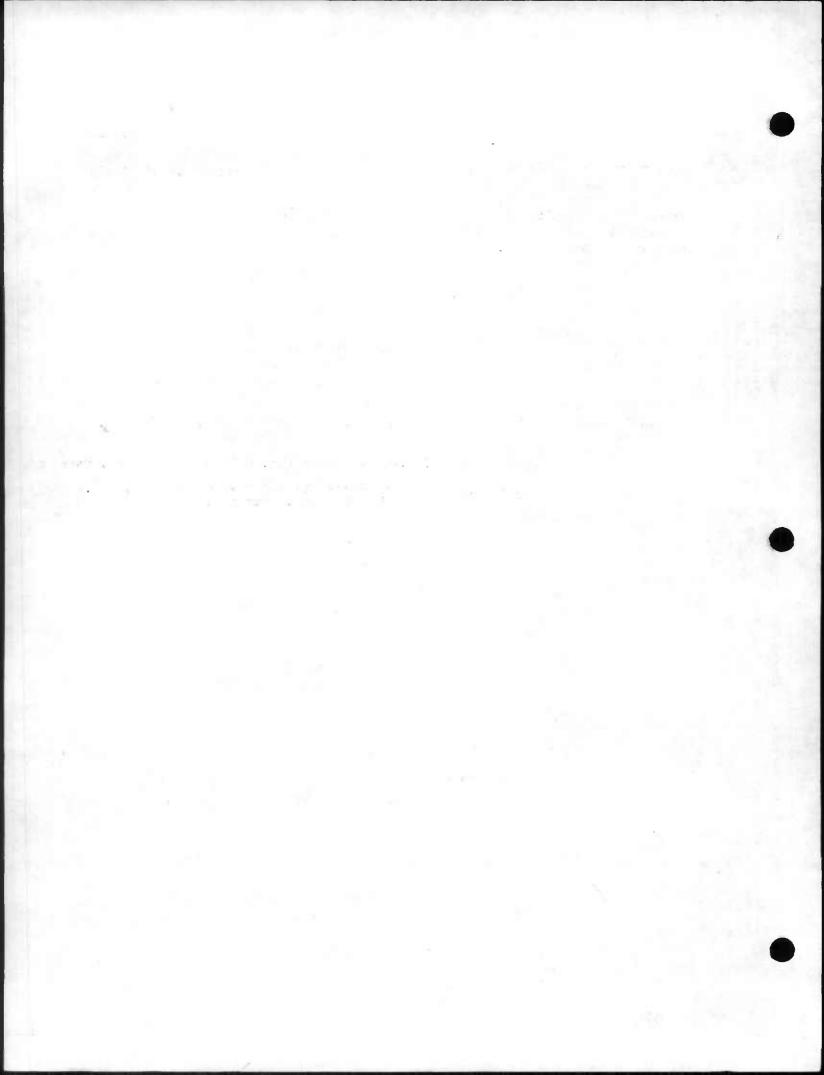
2 Medical Examiner: On the basts of examinetion and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar steted. 29e. Certifier 29b. Signature and title of certifier 29c. Licanse number 29d. Data signed (Month, Dev. Year) 30. Nema and address of person who completed cause of deeth (Item 23e) (Type, Print) 21222 AVE. Dundalk.

And

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Yeer)

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene C Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 7:00am JOSEPH PATRICK CROKE APRIL 1999 4a. Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Deeth 12515 Eastern Blvd. Middle River Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) Deys 1XM 2□ F Yrs. 020-18-8721 Sept. 4 1921 Massachusetts Usuel Residence of Decedent 10a Stete 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Md. **Baltimore** Middle River 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12515 Eastern Blvd. 21220 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Tes 2 No Specify: White Specify: 3 X Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Pharmacuticle Route Salesman 12th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown Lillian Croke 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Peggy Conner / daughter 12515 Eastern Blvd. Baltimore Md. 21220 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stele 12 Burial 2 Cremation 3 Removel from State 4/29/99 Holly Hill Cemetery Baltimore Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Connelly Funeral Home of Essex 0 300 Mace Ave. Baltimore Md. 21221 mu 23a. Pert1. Enier the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line. Approximate Intervel Between Onset end Death Immediate Ceuse (Finel endstage diseese or condition resulting in deeth) Due to (or as Consequence of) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in death) Lesl Due to (or es e consequence of): Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to 24a. Wes en autopsy completion of ceuse of deeth? 1 Yes 1 Yes 2 No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Director

7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Madical Examinar mast be notified at

permit. Pagas 1 end 2 should be filed within 72 hours aftar t Departmant of Health end Mantel Hygiane. Important: If them 27 is marked other than "naturelt, or ther any injury or other traumette event, the Madical Examinar

Baltimore, Maryland 21215-0020

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P.O. Box 68760, 99 Records. Division of Vital funaral or Attending Parter death. filled in by tha To the Hospital c within 24 hours af To the Funeral D complately filled i

Examiner Physician/Medical by Completed Be 2 Certification:

State Registrar

DHMH 16 Rev 6/95

Medical

5 Pending investigation

6 Could not be determined

29c. License number

1 ☐ Yes 2 ☐ No

Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medicel Exeminer: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29d. Dete signed (Month, Dey, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

KAYUN M. DOVE MD 80 28 12

8028 Ritchie Huy Pasadera MD 2/182

31. Dele filed (Month, Dey, Year)

29b. Signeture and title of certifier

1 Natural

2 Accident

4 Homicide

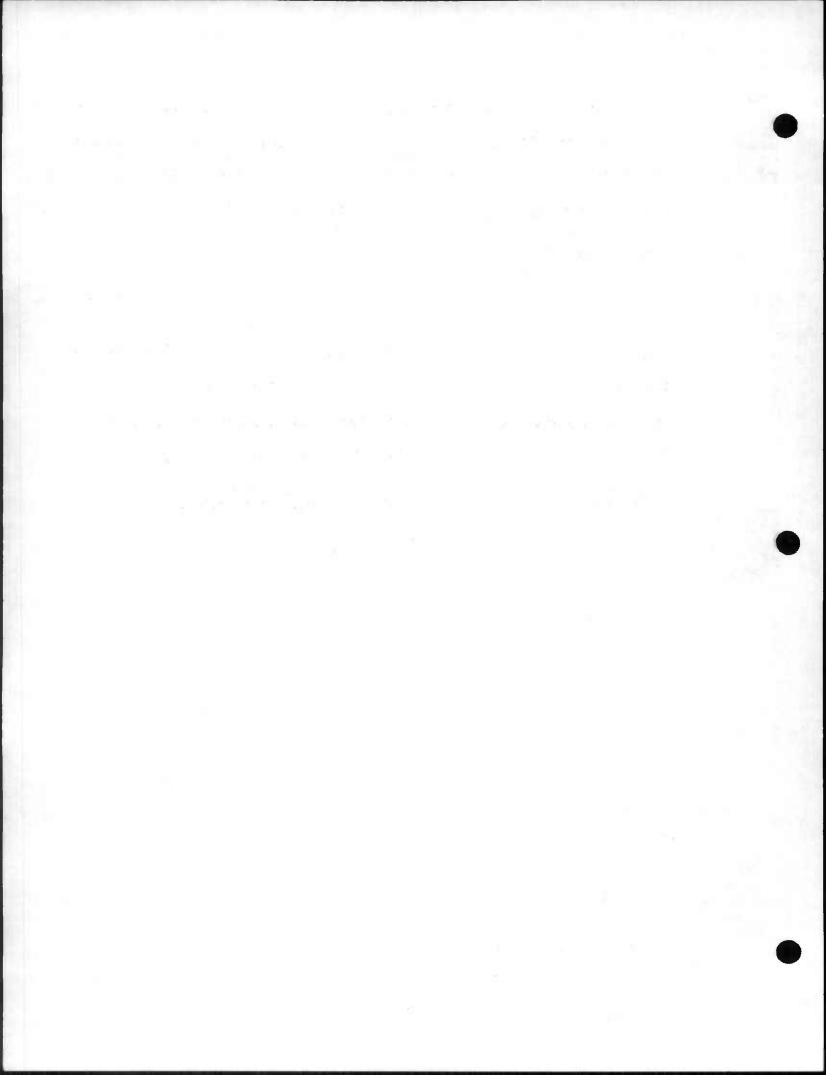
3 Sulcide

29a. Certifier

APR 3 0 1999



28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Year RONALD COLLINS 11:45 pm APRIL 23 1999 4a Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (Steta or Foraign Country) Deys 17 M 2□ F 63 Yrs 375-32-4061 Nov. 20, 1935 Michigan Usual Residence of Deceden 10a State 10b Counts 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1327 Farrara Drive 21113 USA 12. Wes Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, atc. 11. Maritel Status 1 Yes 2 □ No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sergeant FC U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond Collins Lydia Pratt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Jean A. Collins (Wife) 1327 Farrara Drive, Odenton, MD 21113 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2X Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 04/28 Baltimore, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on sech line. Approximata Intervel Betw Onset end Death Immediate Cause (Final disease or condition resulting in death) ASYSTOLE 30 MINUTES Due to (or as a consequence of): CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): Dua to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Wera autopsy findings available prior to completion of cause of death?

1 ☐ Yas 2 No

29d. Date signed (Month, Day, Year) APRIL 23, 1999

BALTIMORE, MARYLAND 21287

Physician /Medical Examiner

Physician

/Medical

Examiner

MI

Director

Funeral

P

Completed

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if Itam 27 is merked other than "natural", or frems 23s or 28s-f show sup figury or other traumstic avant, the Medical Examples must be morthed at page.

Saitlmore, Maryland 21215-0020

Box 68760.

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Division of Vital

physician and s the burial-transit cartificata be axecuted 88 189 been signal has paga 2 cartificate this To the Hospital or Attanding Pt within 24 hours after dash. To the Funeral Director: After th completely filled in by the funera

Examiner Physician/Medical by Completed Be 10 Director: After the din by the funare Certification:

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that initieted events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2/2 No 1 Yas 25. Wes casa refarred to medical examiner? 26. Place of Death (Check only ona) Hospitel: 1 Impatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledga, death occurred at the tima, data and place, and due to tha cause(s) and mannar as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier

State Registrar

APR 3 0 1999 **DHMH 16 Rev 6/95**

SEREMY

(Check only one)

29b. Signatura and title of certifier

31. Date filed (Month, Day, Year)

ZA

32. Registrar's Signeture

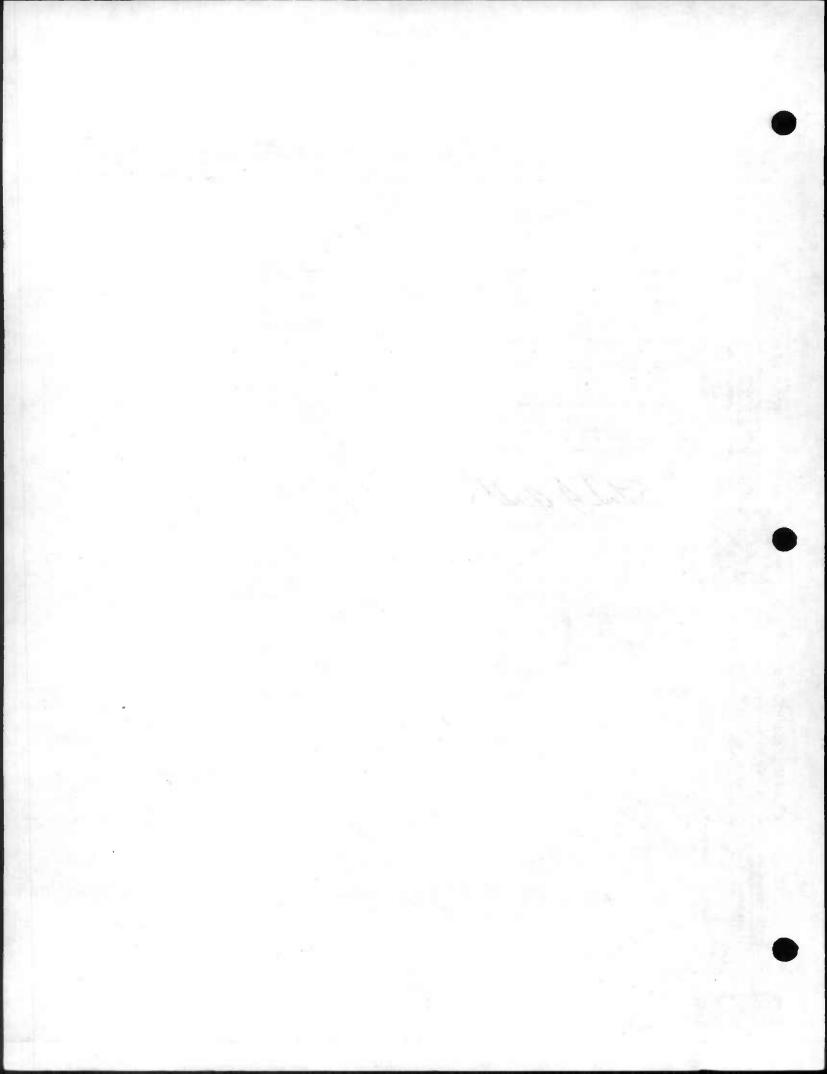
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

WKLIAMS

29c. License number

000

600 NORTH WOLFE STREET



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death April 28, 1999 Physician Pat sy J. Constantino 0315 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Genesis Eldercare - Spa Creek Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** 10 M 2□ F Months Days Hours Min 160-12-1124 Yrs. Director June 15,1916 Pennsylvania **Usual Residence of Decedent** the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2√ No Director notifie Anne Arundel Annapolis 10a Street and Number 10f. Zip Code 10g. Citizan of What Country? must be n 940 Bay Forest Drive 21403 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. 11 Marital Status Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mertals Hyglene.

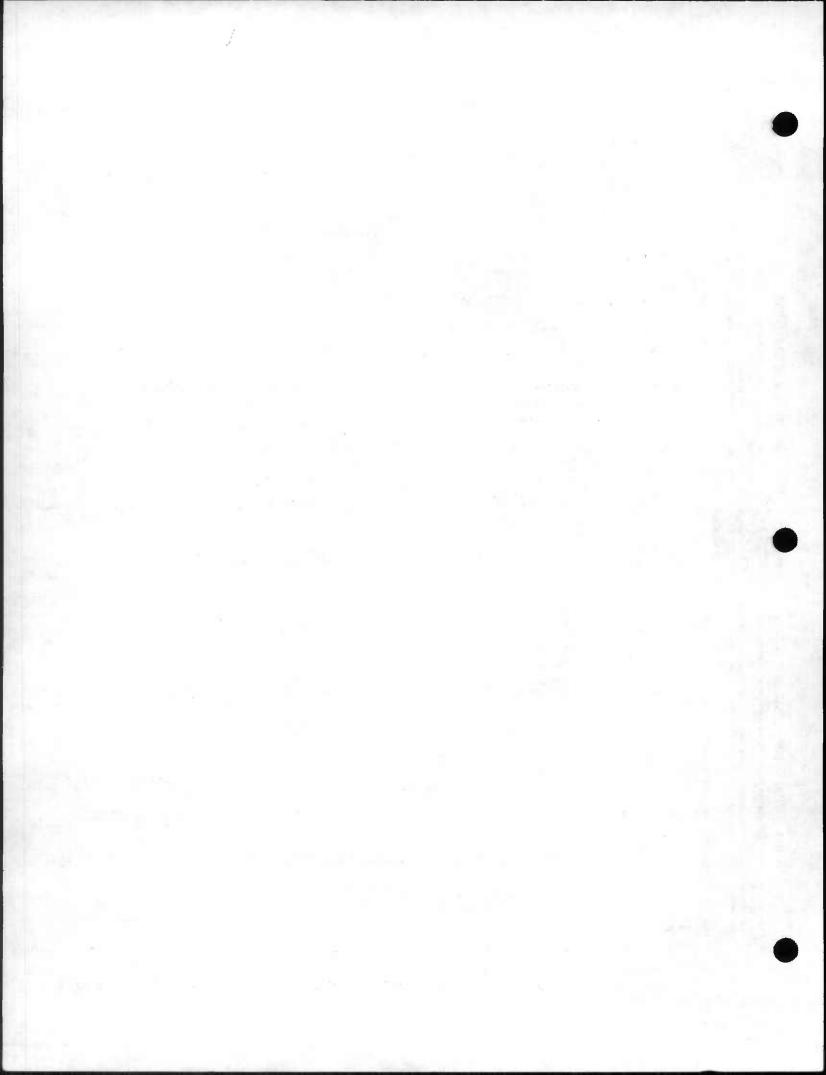
Hit If Item 27 is marked other than "netural", or the truth of the transfer event, the Medical Examples in yor other transmitters event, the Medical Examples. 1 [X] Yas 2 □ No If Yes, Giva Year or Datas: WWII 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: Specify: White p 3 Widowed 4XX Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Restaurant 4 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surnama) 89 Angelo Constantino Maria Antonia Barbaro 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mary Jeffers (Ex-wife) 1230 Garrett Avenue, Churchton, MD 20733 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of important: If any injury or Woodfield Cemetery 05/01 Galesville, MD 21. Signature of Funeral Service License 22. Nama and Addrass of Facility any l Hardesty Funeral Home, P.A. 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. 21401 Approximata Intervat Batween Onset and Death Physician /Medical Immediata Cause (Final disease or condition resulting in death) CORUBRA HONORMHAGUE (Examiner Dua to (or as a consequence of) Examiner Attending Physician: The law requires that the deeth certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): US0 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? á 1 ☐ Yes 2 ☐ No 3 Probably 42 Unknown page 2 should be de Division of Vital Records, p 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? After this certificate 1 Yes 1 ☐ Yas 2 ☐ No funeral director. Be 25. Was case referred to medical axaminer? 26. Placa ol Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Natural death. 1 Yes 2 No investigation 2 ☐ Accident efter death Director: \$ 3 Suicide 6 Could not be To the Hospital or Atte within 24 hours etter de To the Funeral Directo completaly filled in by the 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D41698 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RINGON BUT, ANAMOUS, MP 21401 STOPHEN C. IAMMUNON 32, Registrar's Signatura 31. Data filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

APR 3 0 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Death 27, 1999 6:50pm Virginia Collett - LaRue April 4a Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death 7927 35th Street Rosedale Baltimore 7. Aga (In yrs. last birthday) If Undar 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 4-10-15 Birthplace (Stata or Foreign Country) MD 5. Social Security Number 6. Sax Months Deys Hours Min 213-09-6983 1□ M 2♥ F 84 Yrs. Usual Rasidance of Decedent 10a Stata 10b Count 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Rosedale 1 Yas 2 No 10e. Street and Number 7927 35t 10f. Zip Code 10g. Citizan of What Country? 35th 21237 Street USA 14. Race - Amarican Indian, Black, White, etc. 12. Was Dacedant Evar in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Maritel Stetus 1 Navar Married 2 Married 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Yas 2 No Specify: Specify: white 3X Widowed 4 □ Divorced Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) George H. Hohman 18. Mothar's Name (First, Middla, Maidan Sumama) Viola Bell 19a. Informant's Name/Ralationship (Type, Print) Virginia Fuss / daughter 19b. Malling Addrass (Straat and Number or Rurel Route Number, City or Town, Stata, Zip Coda) 7929 35th Street, Rosedale, MD 21237 20b. Place of Disposition (Neme of camatary, cramatory or other place) Oak Lawn 20c. Location - City or Town, Stata 20a. Mathod of Disposition V☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 5-1-99 Baltimore. MD 22. Nama and Address of Facility Cvach/Rosedale Funeral Home 20 1211 Chesaco Ave. Rosedale, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onsat and Death Immediata Causa (Final diseasa or condition resulting in death) GASTric 3 Month phom Sequantially list conditions, if any, leading to Immediete ceusa. Entar Undarlying Ceusa (Disease or Injury that initiated avants resulting In death) Lest Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Wera eutopsy findings available prior to ost Eo povosis 24a. Was an autopsy performed? completion of cause of deeth? 1 ☐ Yes 2 No 25. Was casa rafarrad to medical axaminar? 26. Piece of Deeth (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital: 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Daath 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Time of 1 Natural 2 Accidant 5 Pending 1 ☐ Yas 2 No Investigation 6 Could not be 3 Suicide Location (Streat and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

physician end s the burial-transit 80 esn certificate has t Hospital or Attending Physician: the funeral director, Aftar this 24 hours after death. Funeral Director: A filled in by completely To the within 2

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens. Improcured to the training the marked other than "netural", or items 28a or 28a-f show any injury or other traumatic event, the Mental

Physician

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Physician/Medical Examiner

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29e. Cartifiar

(Check only one)

29b. Signatura and titla of certifiar

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Baltimore, Maryland 21215-0020

State Registrar

31. Data filed (Month, Day, Year)

and 30. Neme and address of person who complete

causa of death (Item 23a) (Type, Print)

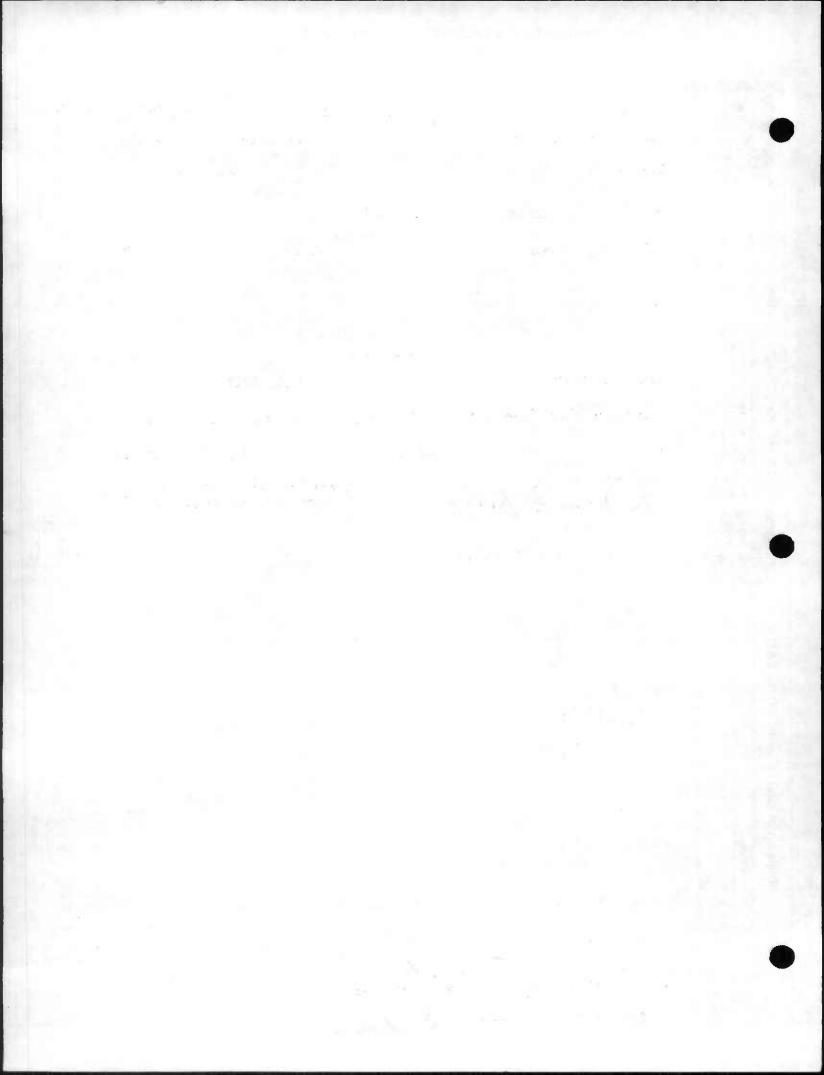
29c. Licansa number

Certifying Physician: To tha best of my knowledge, daath occurred at tha tima, data and place, and dua to the ceuse(s) end menner es stated.

2 Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, date end place, end due to tha ceusa(s) and mannar statad. 29d. Data signad (Month, Dey, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death 26,1999 Month **Physician** Julian W. Cierkes April 11:45am /Medical 4a Facility Name (If not institution, give street end number)
Franklin Woods Rehabilitation Center 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rosedale Baltimore 5. Social Security Number 213-10-3276 7. Age (In yrs. lest birthday). 86 Yrs. If Under 1 Yaar if Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 10-18-12 Birthplace (State or Foreign Country) **Funeral** 10XM 20 F Months Days Hours Director MD Usual Residence of Decedent 10b. County with the Marylence 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinet must be notified at MD Baltimore Rosedale 1 Yas 2 No Director 10f. Zip Code 21237 10e. Street and Number 1217 N. 62nd Street 10g. Citizen of What Country? USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 247 No If Yes, Give^X Year or Dates: 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amaricen Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours effer of the file and Mental Hygiene.

If I fem 27 is marked other than "natural", or item 1 Naver Marriad 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 6 0 reporter/photographer East Baltimore Guide 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fathar's Nama (First, Middle, Last) Rozalia Korytkowska Julian Cierkes Sr. 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Straet and Number or Rural Routa Number, City or Town, Stete, Zip Code) 1217 N. 62nd Street, Rosedale, MD Joanna Chelette / daughter Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place)
Metro Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stata 8 4-27-99 Department (Catonsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensi 22. Nama and Address of Facility Cvach/Rosedale Funeral Home 23a. Part1. Enter the disease, or complications that caused the Wath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** e ACUTE MYOCARDIAL INFARCTION
Due to (or as e consequence of): /Medical Immediate Cause (Final disease or condition resulting in death) 1 HOUR Examiner ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Examiner >15 YEARS physician and the burial-tran Sequentially list conditions, if any, leeding to immediate couse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the undarlying ceuse givan in Part I. 23b. Did tobacco use contributa to the cause of death? the signed by t 1 Yes 2 No 3 Probably 4 Unknown ATRIAL FIBRILLATION þ 24b. Were autopsy findings available prior to complation of causa of deeth? 24a. Was an autopsy performed? Completed RECENT CEREBROVARCULAR ACCIDENT has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: eftar death. Director: After this carific 25. Was cese referred to medicel examiner?
1 ☐ Yes 2 ☐ No funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Downsing Home 5 Residence 6 Other (Specify) Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 DNaturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, straet, factory, office building, etc. (Specify) 4 Homicide • Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and mannar stated. edical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier 29d. Date/signed (Month, Dey, Year) 29c. Licansa number 30. Name and address of person who completed cause of leath (Item 23a) (Type, Print)

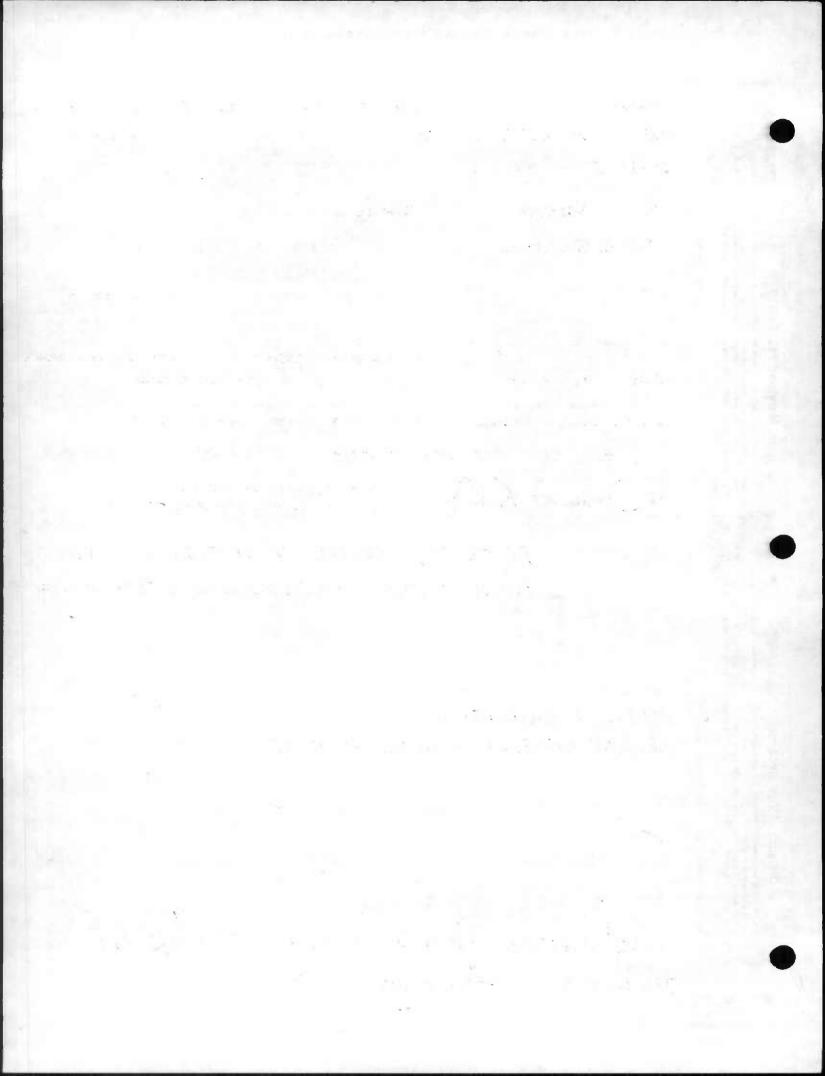
7811 LINCE WE., BALTIMORE

State Registrar

31. Date filed (Month, Dey, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Deeth SYLVIA 8:32 PM ADA DEAN April 2
4b. City, Town, or Location of Death 25, 1999 th 4c. County of Deeth 4a Facility Nama (If not institution, giva straat end number) SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplaca (Stata or Foraign Country) Months Days Hours Min 1 □ M 3 → Yrs. 097-03-2786 90 Aug. 4, 1908 | Pennsylvania Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6912 01d Stage Road 20852 U.S.A. 12. Wes Decedant Evar in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No 14. Race - American Indien, Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Black, Whita, etc. 1 Nevar Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 25 No Specify: Specify 3 Widowed 4 ☐ Divorced White 16e. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast greda completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Accounting 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Meyer S. Eisenberg Hannah Felberbaum 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Robert Dean, Son 6912 Old Stage Road, Rockville, Maryland 20852 20b. Piece of Disposition (Nema of cemetery, cremetory or other place) 20a. Method of Disposition 4/28/1999 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Alexandria, Virginia Metropolitan Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee STEIN "HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, NW, WASHINGTON, DC 20012 cos 23a. Peri1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onsat and Death ancer Immadiate Cause (Final eaus disease or condition resulting in deeth) ulmonary Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated avants resulting in deeth) Lest Due to (or as a consequence of): Meterstaser Due to (or as a consequance of): Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yee 2 No 3 Probably ★ Unknown 24b. Were eutopsy findings available prior to completion of causa of deeth? 24a. Wes en eutopsy 1 Ves 2 □ No 1 ☐ Yas 2 X No 25. Was cese referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas XXNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Yaer) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

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Physician

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parmit. Pege Department of Important: If any injury or

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Certification:

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Baltimore, Maryland 21215-0020

with the Maryland

death

State Registrar

31. Dete filed (Month, Day, Year, APR 3 0 1999

4 Homicide

29b. Signature and title of certil

29e. Certifier



rson who completed cause of death (Item 23e) (Type, Print)

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)



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Cardiving Phyelclen: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) and partier steted.

29c. License number

29d. Date signed (Month, Dey, Year)

Germantown, mo

DHMH 16 Rev 6/95

To the Within 2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death Month Day 6:11pm Emory August Frederick Eckes 4b. City, Town, or Location of Death 28 4a Facility Name (II not institution, give street and number) 4c. County of Death Baltimore City N/A Union Memorial Hospital 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) July / 1922 Birthplece (State or Foreign Country) Days Months Hours 150 M 2□ F 76 217-18-9489 Maryland Usuat Residence of Decedent 10a State 10b. County 10c. City. Town or Location t0d. Inside City Limits 1 ☐ Yes 2 No Dundalk Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 1723 Ranch Lane 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritat Status Bleck, White, etc. 1 Never Married 2 Norried 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Lead Press Oven Operator Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Anna Margaret Hofmann August Eckes 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1723 Ranch Lane Dundalk, Maryland 21222 19a. tnformant's Name/Relationship (Type, Print) Dundalk, Maryland Mrs. Helvi H. Eckes/Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 4 Donation 5 ☐Other (Specify) Hillton Service Corp. 5/3/1999 Towson, Maryland 21. Signature of Fundal Service Licenses 22. Neme end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter the disease, or complications that caused and deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each just. Approximete Interval Between Onset and Death Immediate Cause (Final BILATERAL PNEUMONIA disease or condition resulting in death) Due to (or es e consequence of): STAGE LUNG DISEASE END Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) DISEASE C'ORONARY ARTERY Due to (or as a consequence of) 23h. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one)

/Medical Examiner Examiner physician and the burial-transit that the death cartificeta be asscuted Box 68760. Physician/Medical 987 ò Records, P.O. the signed b by bloods Completed has cartificate Division of Vital or Attending Physicien: 89 Certification: To this After thi funeral death. the Funeral Director: And Funeral Director: And Funeral Director: And Funeral Filled in by the To the Hospital o within 24 hours of To the Funeral D

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permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygiena important: if Item 27 ie marked other that any injury or other traument.

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Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes case referred to medical Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

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29b. Signeture end title of certifie

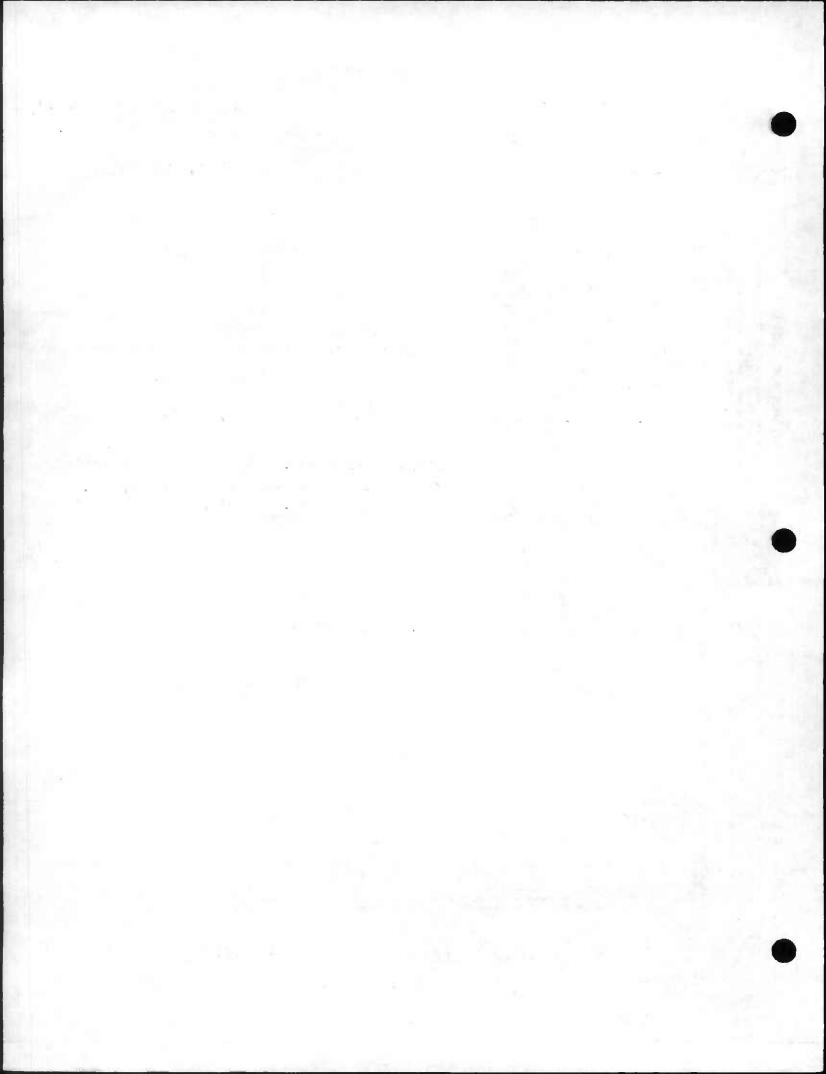
30. Name and address of person

31. Date filed (Month, Day, Year)

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no completed cause of death (Item 23a) (Type, Print)

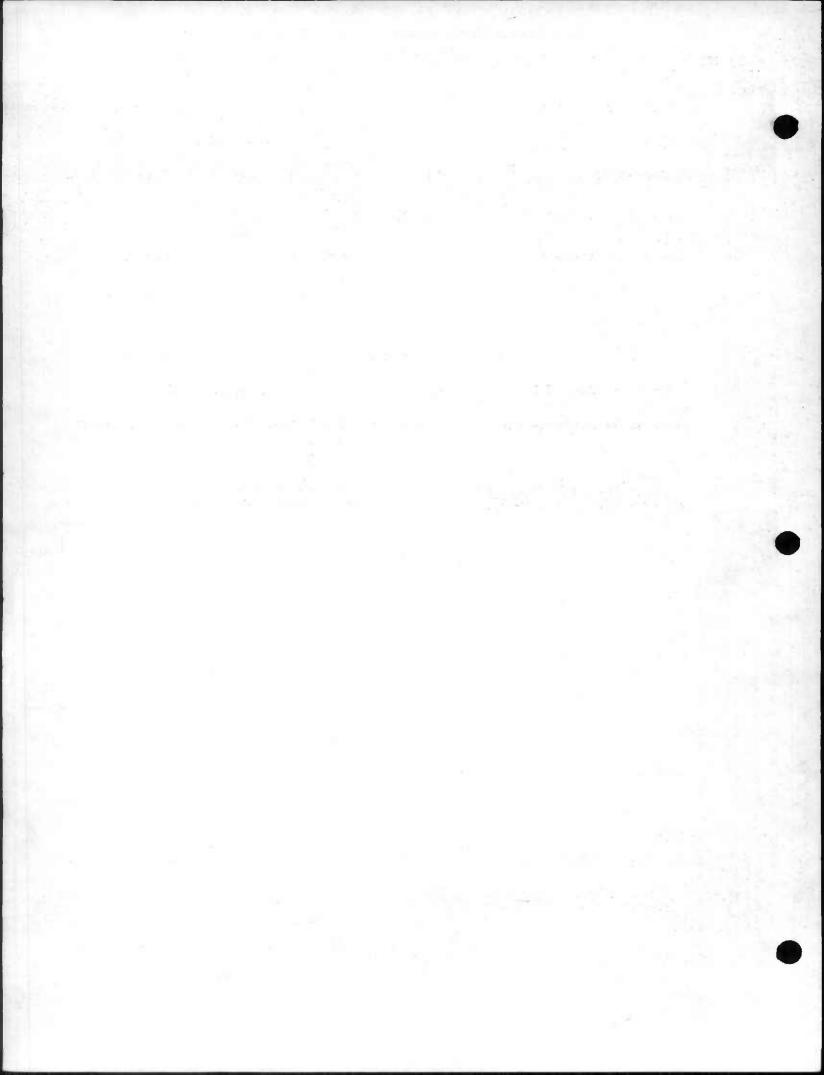


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEMS: #17, 18 PER F,H, G773 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Audrey King Fox APHIL 23 11:20 An. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HAURE-de-GRACE Citizens Nursing HARford Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthpiace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F 83 -84 Yrs. Director 212-14-8259 April 27, 1915 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Harford Maryland Havre de Grace 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 415 Market Street 21078 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 2 should be filed within 72 hours after c and Mental Hygiene. s marked other than "natural", or Iten 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White þ 3 € Widowed 4 Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 0 Home maker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 10 Emma R. Atkinson KING Harry B. King ATKINSON permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harriet Raines/daughter 1009 Ocotillo Drive, Sierra Vista, AZ 85635-1209 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name end Address of Facility Wade. Director State Anatomy Board, 655 W. Baltimore Street 21201 Baltimore, Maryland 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, hock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Finel diseese or condition resulting in death) Seps is / Dehydration
Due to (or as a consequence of): 1 week Examiner Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or as e consequenca of): physician a the burlat-Box 68760, Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed to Division of Vital Records. by Gastrointestral bleed 24a. Was an autopsy performed? 24b. Were autopsy findings eveileble prior to completion of cause of death? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 🔯 No Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA | Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral D completely illed Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) end manner stated. 29a, Certifier (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) Phy Siaan D43115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIRZA A-BALL MD 615 S. Ulman Are, HAVRE DEGRACE MD

21. Date filed (Month Pay York) 31. Date filed (Month, Day, Year) State 'pewa Registrar

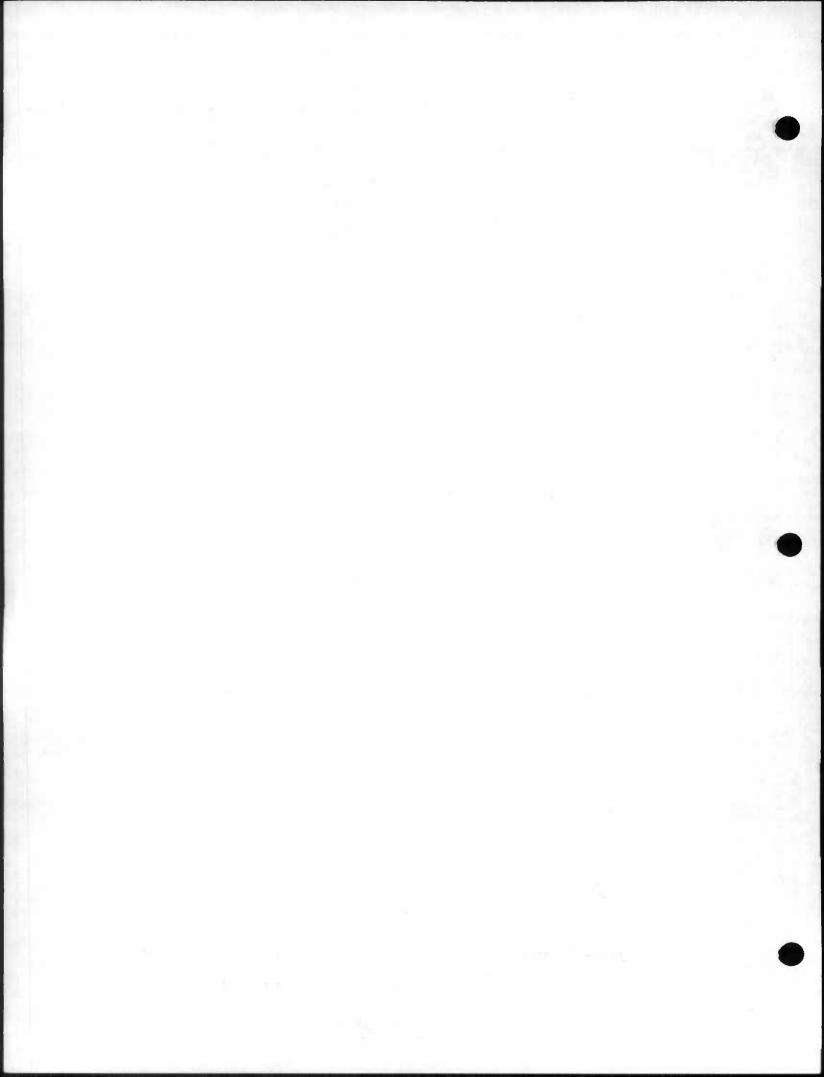


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State of Maryland / Department of Health and Mental Hygiene

14061

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h. After this certific funeral director Ilon: To Be		5. Was cese referred to medical examiner? 1 Yes 2 146			ER/Outpatient	3□ DOA	0.11	eath <i>(Check only</i> Home 5□ Resi		ner (Specify)			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Data of Daeth April 27, 1999 11:10pm Thurman Eugene Ford, Jr. 4a Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth VAMHCS Fort Howard Division Fort Howard Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) Months 62 Yrs. July 4, 1936 Maryland 213341599 Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Md. Baltimore Baltimore 10e. Street end Number 10f Zin Code 10g. Citizen of Whet Country? 5216 Arbutus Avenue 21227 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 DAYes 2 No If Yes, Give Yeer or Dates: 1955-57 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race · American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 9th Crane Operator Water Construction 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Thurman Eugene Ford, Sr. Marquerite Elizabeth Callis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Saundra L. Byrd (Sister) 5216 Arbutus Avenue Baltimore, Maryland 21227 20b. Plece of Disposition (Neme of cemetery, cremetory or other placa) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Burial 2 Cremetion 3 Removel from Stete Md. Veterans Cemetery 4/30/99 Crownsville, Maryland 4 Donetion 5 Other (Specify) 21 Signature of Suneral Sarvice Licensae Kevin E. McCully-Polyniak Funeral Home P.A. Ecker 237 E. Patapsco Avenue Baltimore, Maryland 21225 23a Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each lina. Approximete intervel Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in death) Squamous Cell Carcinoma of Soft Palate and Neck 12 months Due to (or as e consequence of): Macrocytic Anemia Years Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequance of): Chronic Alcoholism Years Due to (or es e consequença of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to deeth but not resulting in the underlying causa given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings eveilable prior to 24e. Was en eutopsy performad? complation of causa of deeth? 1 Yes 2 No 1 ☐ Yes XX No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: i2□finpatient 2□ER/Outpatient 3□ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2KN0o 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. injury et Work? 1 KNatural 5 Pending 1 ☐ Yes 2 ☐ No invastigation 2 Accident 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Straet end Number or Rurel Routa Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and dua to the ceuse(s) end menner es steted.

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Baltimore, Maryland 21215-0020

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31. Date filed (Month, Day, Year)

32. Registrer's Signeture

Jugustin Chine, mx 30. Nema end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

> books APR & 0 1999

Augustin Chyu, MD 9600 North Point Road, Fort Howard, MD 21052

DHMH 16 Rev 6/95

Registrar

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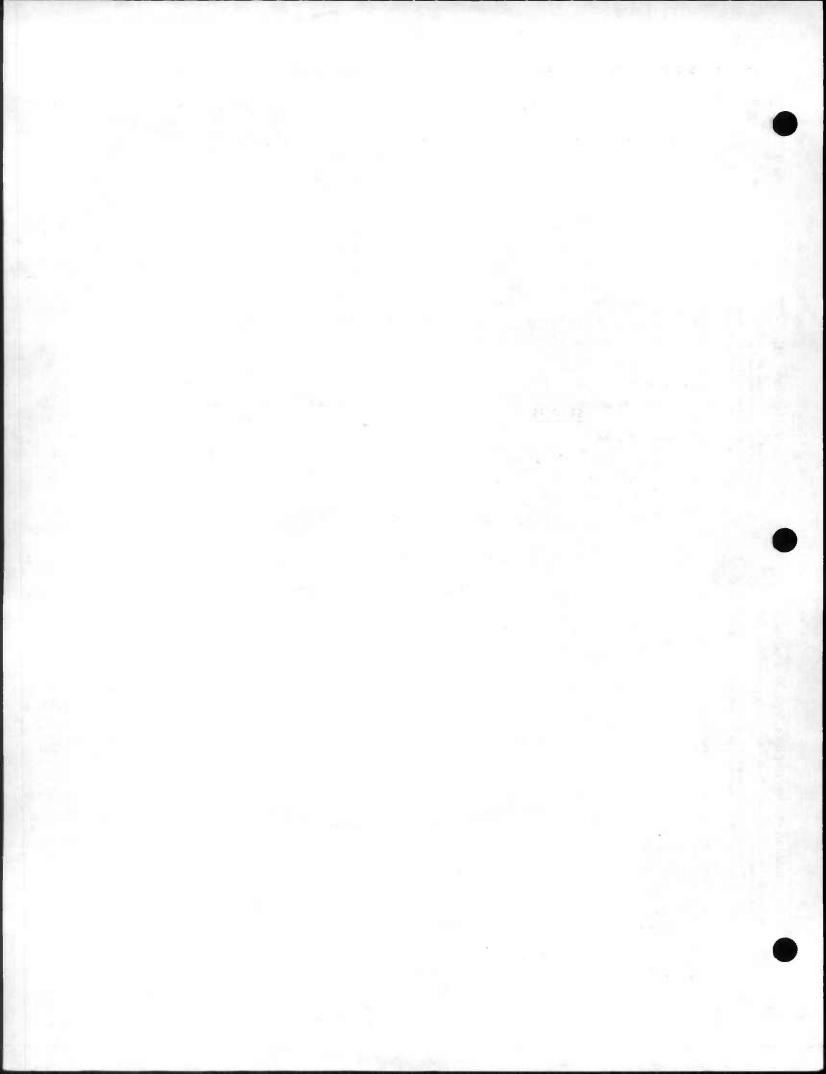
State of Maryland / Department of Health and Mental Hygiene

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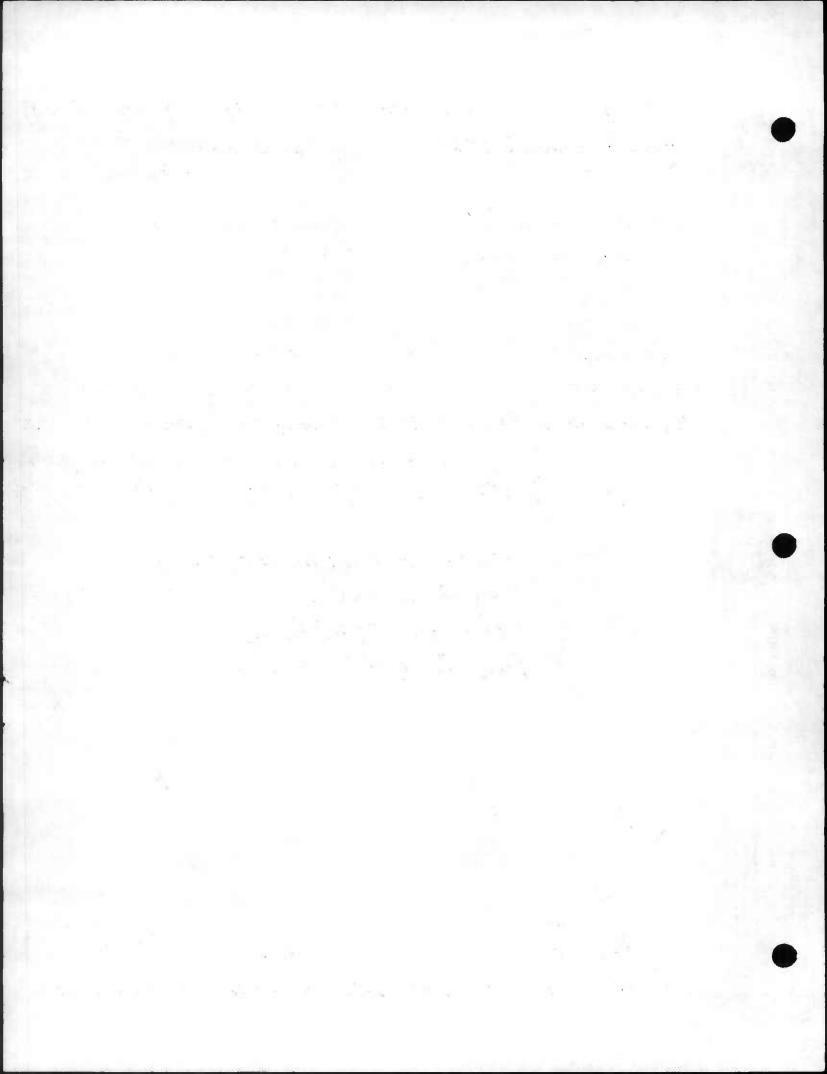
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210 03 3200	6ex 7. Age (In 97	yrs. last birthday) Yrs.	If Under 1 Yea Months Days	r If Under 24 Hr Hours Mir	8. Date of Birth Month, Day 08/12/13	got"	9. Birthplaca (State or Country) Mary land				
Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City				
MD N/A 10e. Street and Number	В	altimore					1)(□ Yes				
	ue		10f. Zip Code 21206			10g. Citizen of What Country? United States					
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of If Yas, specify Cul	ban, Mexican, Pue	Specify Yes or No- irto Rican, atc.)	Black	a-American Indian, k, White, etc. White				
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Unknown Chal	Type, Print)				Baltimore						
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21. Signature of Foreral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 212											
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					1 U Y	es 200 No	1 □ Yes 2 □				
25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ☐ ER/Outpatier	nt 3 DOA	. /	eath (Check only of Home 5 Resid		ar (Specify)				
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea		28c. Inju			ow injury occurr					
3 Suicide 6 Could not be detarmined	280. Place of injury - A	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the treatment occurred at the tr	ime, data and place opinion, death occ	e, and due to the courred at tha tima, o	ause(s) and ma lata and place, a	nnar as stated. and dua to tha cause(s)				
29b. Signature and title of codifier	adeya -			ise number		29d. Date signed	(Month, Day, Year)				
1 (your	7 17 BYLA	(AVICOS	DS	22 28		1/2	9/99				
30. Name and address of person who V · 18 HA LOD 1.4 A , 191	completed cause of death (tem 23a) (Type, NORTHE	DS Print) PRH PKWY	1 18AU	TINIORE	MID :	21214				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** 4a Facility Name (If not Institution, give street end number /Medical 4c. County of Death 4b. City, Town, or Location of Death 8. Date of Birth (Month, Day, Year) Examiner Birthplace (State or Foreign Gountry) If Under 1 Year Months Days Security Number last birthday) **Funeral** Days Min 247-13-5897 10 M 2X F Hours Director Usual Residence of Decedent deeth with the Meryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show adical Examiner must be notified at Yes 2 No Director MARYLAND 10e. Street and Number 10f. Zip Coo 10g. Citizen of What Country? USA RIVE VIEL I Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. should be filed within 72 hours efter ond Mental Hygiene.
marked other than "natural", or Item 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☒ Divorced BLACK Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ASSISTANT 11+#GRADE NURSING 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 end 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked ofthe any lijury or other traumatic event OREs. Be MOSS EVOE HERBERT CHRISTINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) CAREY STREET, 20b. Plece of Disposition (Name of cemetery, crematory or other place) CHRISTINE HOSS BALTI MORE, MD. 2/223 20c. Location - City or Town, State MOTHER) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State CEMETERY 04-30-99 LANSDOWNE, MARYLAND 4 Donation 5 Other (Specify) N 21. Signature of 22. Name and Address of Facility Fund at Service Lice JOSE PH BROWN 4LTON AVE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Excephalopathy disease or condition resulting in death) Examiner Examiner ettending physician and for use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical signed by the el Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? Unknown 1 ☐ Yes 2 ☐ No 3 Probably p 24b. Were eutopsy findings available prior to should should Completed 24a. Was an autopsy performed? completion of cause of death? this certificete hes rel director, page 2 1 ☐ Yes 2 ☐ No A Hospital or Attending Physician: 24 hours efter death.
Funeral Director: After this certifice etely filled in by the funeral director. Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No 27. Manner of Peath Other: 4 Nursing Home 5 Residence 6 Other (Specify) ^oL 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 🗆 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital o within 24 hours eff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and menner stated. Medicai 29a, Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. S. DANG Man. D 32. Registrar's Signa State Registrar **DHMH 16 Rev 6/95**



DHMH 16 Rev 6/95

State

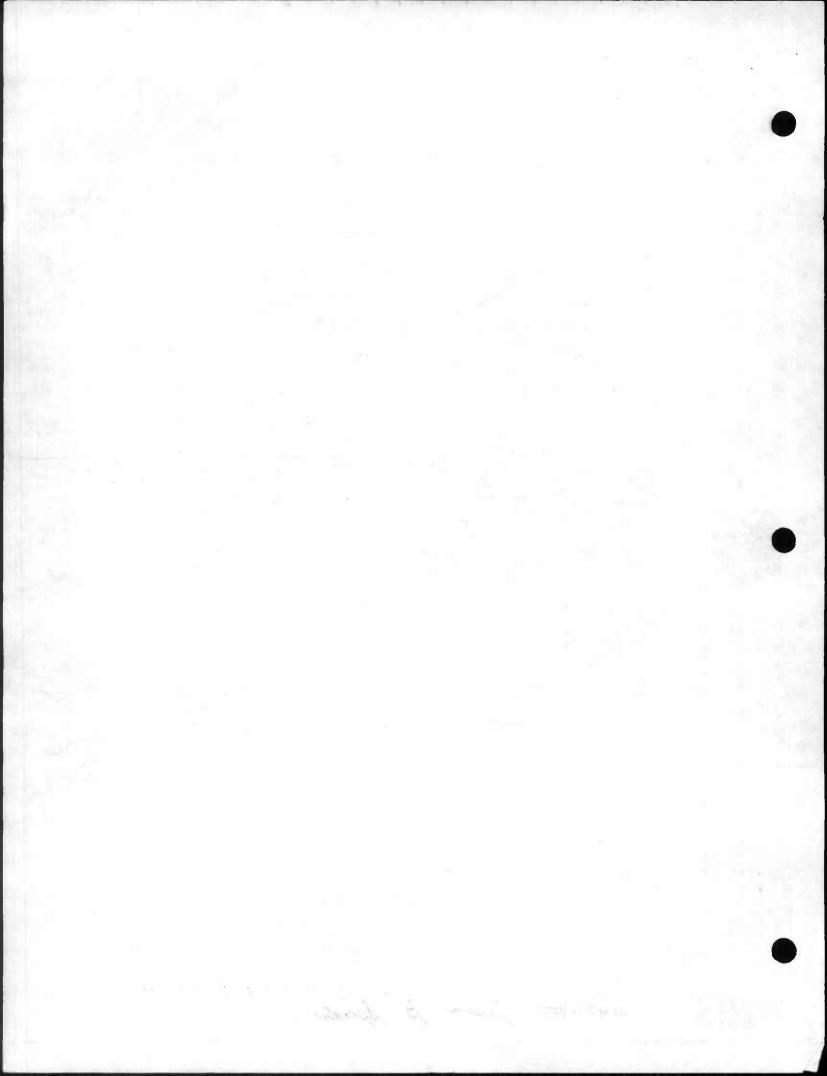
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32. Pegistrar's Signature

APR 3 0

1999

31. Date !



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month HAM KENNETH 5.20 Am 11 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Caton Manor Nursing Home Baltimore if Under 1 Year | if Under 24 Hrs. 8. Dete of Birth (Month, Day, Yeer) 10-08-26 Birthplace (State or Foreign Country) SC 5. Social Security Number 7. Age (In yrs. last birthday) MM 2DF Months Days Hours Min 250 30 9201 72 Yrs. Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No NA Baltimore 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? 852 N. Franklintown Road 21216 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Baca - American Indien. Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry U.S. Steel & Elementary/Secondary (0-12) College (1-4or 5+) Carnegie Pension 8th Grade Crabe Operator 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Jimmie Ham Sander Lucy 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21218 19a. Informent's Name/Relationship (Type, Print) 1407 Northgate Road Baltimore, Maryland of Disposition (Name of Date 20c. Location - City or Town, Stete Devoark Tucker 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Garrison Forest VA Cem. 05-03-99 Owings Mills 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signeture of Funerel Service Licansee Baltimore, Maryland Bemard WM.C.March FH 1101 E. North Avenue21202 23a. Pert1. Enter the disease, or so hplicetions that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death Immediete Ceuse (Finel disease or condition resulting in death) Due to (or es e consequence of Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Due to (or as a consequence of): that initieted events resulting in deeth) Lest Due to (or es e consequença of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 12 Unknown 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? 2 No 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Placerof Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of

Physician /Medical Examiner

Physician

/Medical

Examiner

MD

Director

Funeral

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Completed

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the Maryland

permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylax Deportment of Health and Mental Hygiene. Deportment of Health and Mental Hygiene. Important: if tem 27 is marked other than "natural; or itema 23e or 28e-f show any injury or other traumatic event, trained to the profiled.

altimore, Maryland 21215-0020

Examiner physician and the buriel-transit as esn page 2 s hes

certificate funerel director, this

Physician/Medicai þ Completed P

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

or Attending Physician: 24 hours efter death. filled in by Hospitai

State Registra

Medical

29b. Signeture end title of cartifier

5 Pending

investigation

6 Could not be determined

29c. License number 0 17537

1 📉 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner as steted.

1 Yes 2 No

2 Medical Examiner: On the basis of examination end/or Investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated. 29d. Date signed (Month, Dey, Year) 4-27-99

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1600 W. MOUNT ROYAL AVE BALTO 21217

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

DANHM. S. SALWAM (Item 23a) (Type, Print) DARSHAM: 5. 31. Dete filed (Month, Dey, Year) APR 3 0 32. Registar's Signature

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

DHMH 16 Rev 6/95

within 2 the th

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Yaar **Physician** 11:35 AIM JOHNSON APRIL PAMELA 1900 28 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital Baltimore City If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Year 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 10 M 20 F Months Days 218-98-4405 Yrs. Director Usual Residence of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No NA Director KINGSTON 10e. Street and Number 10g. Citizan of Whet Country? permit. Peges 1 and 2 should be filed within 72 hours efter death with Department of Health and Mentel Hygiana. Important: If item 27 is marked other than "natural", or items 23a or any injury or other treumatic event, the Medical Exactive must be nonce. 41 CHERRY JAMAICA DRIVE TOWNHOUSE Funeral 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yes 2 ☐ No If Yes, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 Never Married 3 Married 1 Yes 2 No Spacify: ð 3 Widowed 4 Divorced BLACK Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) + YEARS DOCTOR UNIVERSITY HOSATAL 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be EDGAR BECK FORD MIRIAM 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 45924 WINDRIDGE LANE, CANTON, MICHIGAN 48188
26 of Disposition (Nama of Dete 20c. Location - City or Town, Stata DONALD CHRISTIAN 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Burial 2 Cramation 3 Ramoval from Stata ST. ANOREW PARISH CHURCH CEMETER 05-08-99 KINGSTON, JAMAICA 4 Donation 5 Othar (Specify) JOSEPH H BROWN JR. FUNERAL HOME, P.A. 3/40 N. FULTON AVE. BALTIMORE, MD. 2/2/17

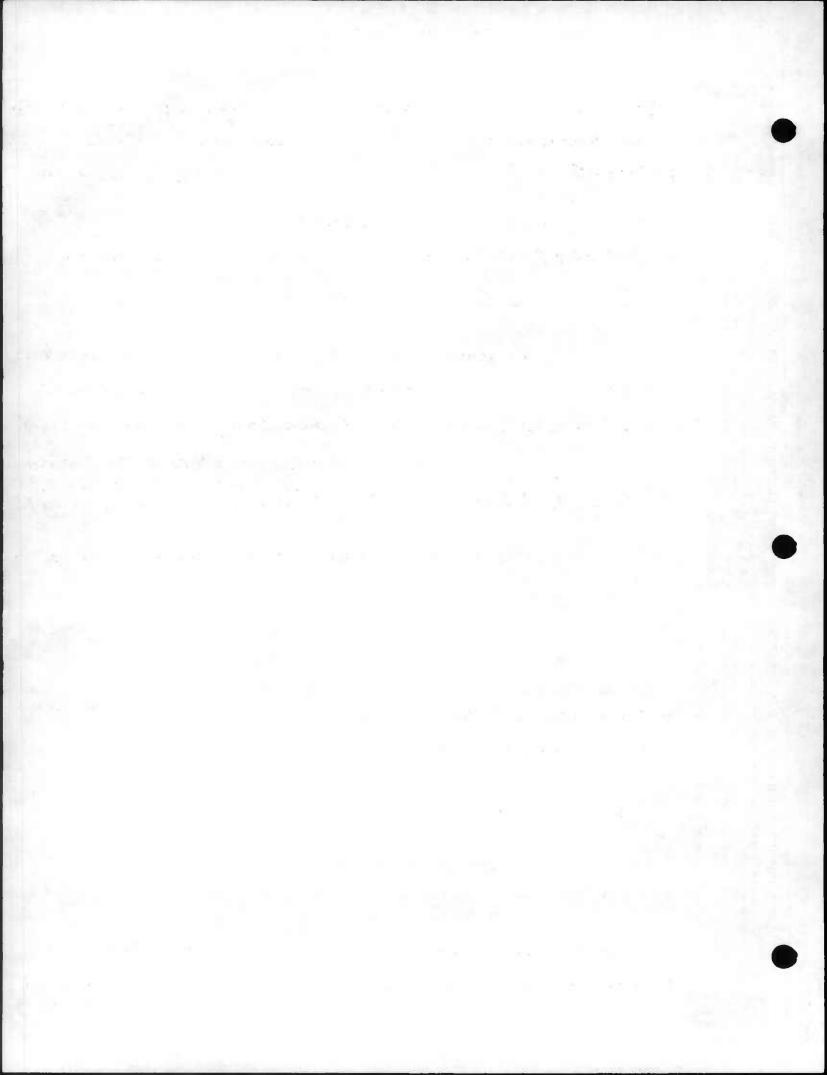
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate

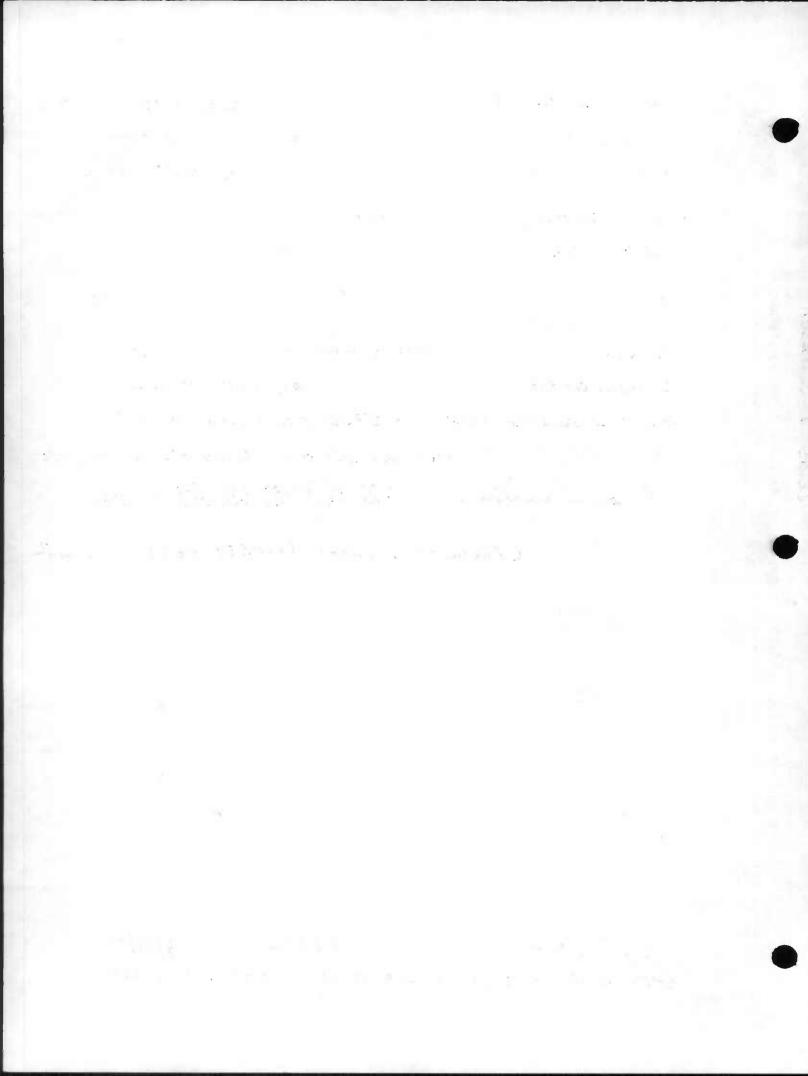
Approximate 21. Signaturo of Finaral Sarvice Lisensas Approximata Interval Between Onset end Death **Physician** /Medical Immediata Causa (Final disaesa or condition resulting in deeth) SQUAMOUS CEll CARCINOMA OF ESOPHAGUS Examiner Dua to (or es e consequence of) Examiner physician end the buriel-trensit The law requires that the deeth certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) 89 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the causa of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No CORNECTIVE TISSUE DISEASE 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed DILATED CARD JOMYODATH complation of cause of death? 2 No 1 Yas 2 No this certificate or Attending Physician: director, 25. Was casa refarred to medical axaminar? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending 1 Naturel 1 ☐ Yes 2 ☐ No death. Investigation ofter death Director: A d in by the f 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, ferm, streat, factory, office building, etc. (Specify) 4 - Homicida within 24 hours eft To the Funeral Di completely filled in 29a, Cartifian 1🕱 Certifying Physician: To tha bast of my knowledge, daath occurred et tha time, dete end plece, and due to the causa(s) and mannar es steted. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. To the I 29c. Licensa number 29b. Signatura end titla of certifier 29d. Date signed (Month, Day, Year) 9. WZ RES-000 HPRIL M.D. 28 II. 30. Name and addrass of parson who complated causa of death (Itam 23a) (Type, Print) RICHARD E. WATERS BALTIMORE JOHNS HOOKINS HOSPITAL 31. Date filed (Month, Day, Year) MARYLAND 32. Ragistrar's Signature State APR 3 0 1998 Registrar

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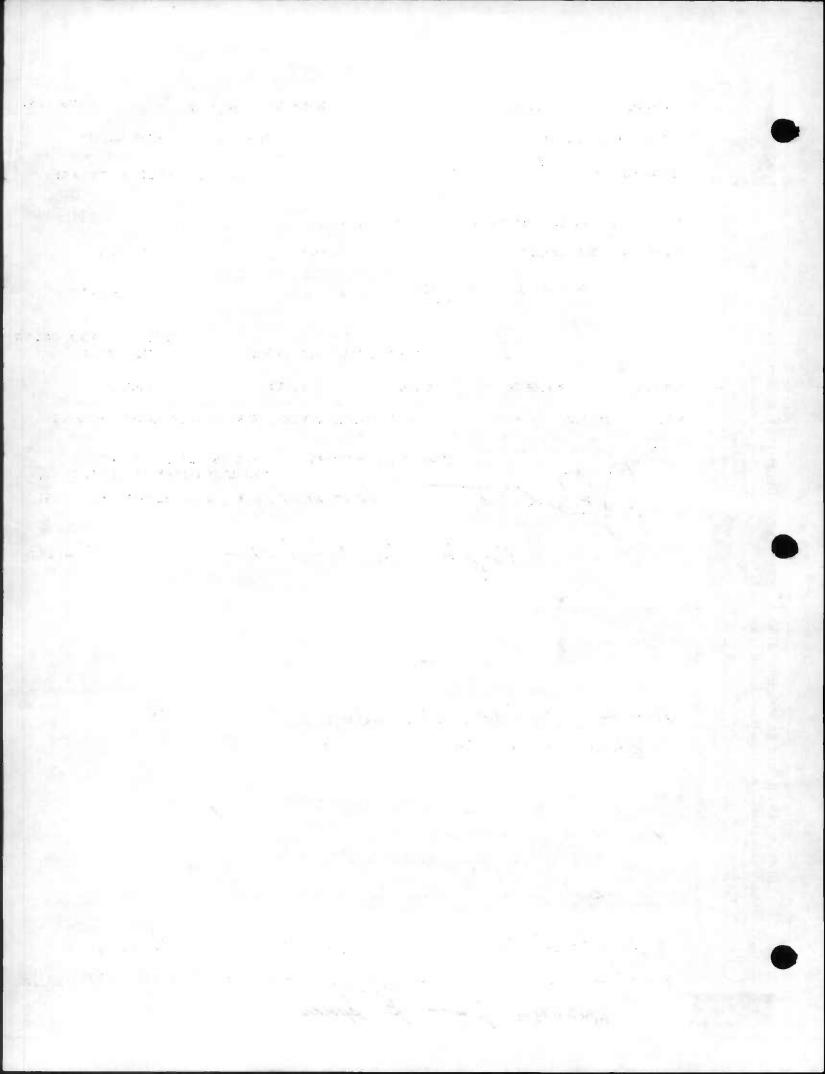


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hysician	1. Decedent's Name (First, Middle, Last) Poris Jane Jentzsch							Mont		Date of Death Month Day Yeer Pril 28, 1999		3. Time of Death 8:20 PM	
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ral or	5. Sociel Security Number		7. Age (In yrs.	last birthday) Yrs.	If Under 1 Months 1	Year Days	If Under 24		Date of Bird (Month, De	y, Year) 9, 1933		plece (Stete or Foreign intry) YLand	
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Funeral Director	10e. Street end Number 324 Worton Ro	ad			10f. Zip C	ode	21221			10g. Citizen of V	.S.A		
Dy I dileia	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	ried 1 Yes	ces? 2 X No	X No 1 ☐ Yes 2X No			of Hispanic Origin? (Specify Yes or No uban, Mexican, Puerlo Rican, etc.) lo Specify:			No- 14. Rece - American II Bleck, White, etc. Specify: White		, etc.	
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o Re C	17. Father's Name (First, Middle, Willie B. Car	ilton					Mary	Flo,	rence	Maiden Sumen Shanaha	n		
ĺ	19a. Informent's Name/Relations Wrs. Martha Sa		dghtr)				end Number Road,				City or Town, State, Zip Code) MD 21713		
	20a. Method of Disposition 1									20c. Location - City or Town, State Elkridge, Maryland			
cian/Medical Examiner	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	e. <u>C A l</u> b c	Due to (c	MA, V or es e consec or es a consec or es e consec	quence of): uence of):	ed N	V PR		FY, 1	METS		Onset and Death 6 nm/L	
by Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobecco use contribute to the cause of dee				
									24a. Was en eutopsy performed?			Vere eutopsy findings weilable prior to completion of cause of deeth?	
within 24 hours efter deeth. To the Funeral Director: After this certificate has been signed by the ette completely filled in by the funeral director, page 2 should be detached for Medical Certification: To Be Completed by Physicial	25. Was case referred to medical examiner?								1 Yes 2 No 1 Yes 2 No				
	1 Yes No 27. Menner of Death 1 Matural 5 Pendii 2 Accident invest 3 Suicide 6 Could 4 Homlcide determ	: Injui		0 28	d. Describe	dence 6 Ottl how injury occu Street end Num. wn, State)	rred	ral Route Number,					
edicai C		ng Physician: To the t Examiner: On the ba and mann	sls of examine										
Me	29b. Signature end title of certifie					ST. BARTINE				29d. Date signed (Month, Dey, Year)			
	30. Name and address of person CAPY Con(EN	MP 65	69 A	n 23e) (Type,	Print) P. (E)	57		BAT	M	0 21	204		
State gistrar	31. Date filed (Month, Day, Year, APR 3 0 19	98	gistrar's Signa	19.	sport	2							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ician		Decedant's Name (First, Middla, Last)					2. Date of D			Tima of Death		
	G	EORGE		HARL	AND			KIMMELL	Month	Day 27. 1999	Yeer 9	:06 A.M.
/Medical Examiner		acility Nema (If	not institution,	give street en	d number)			4b. Cify, Town	, or Location of Dea		-	
	5	4a Facility Nema (If not institution, give street end number) 5806 LARSEN STREET					GLEN	BURNIE	ANN	E ARUND	EL	
al	5. So	clal Security Nu	ımber (6. Sex 1 M 2	7. Age (In yrs. last bii	Months D		Hrs. 8. Date of B	irth Pay, Year)	9. Birthplaca Country)	(Stata or Foraign
or		13-18-		10 M 20		76	Yrs.			5, 1922		
*		I Rasidance of I	10b. County		1	IOc. City, Tow	n or Location				10d. I	nside City Limits
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edical Examiner mant be notified at letted by Funeral Director	10e.	Street and Num		E ARUI	ADEL	G.	10f. Zip Co			10g. Citizen of	What Country?	
	58	06 LAR	RSEN S	TREET				21061		U	.S.A.	
	3	Marital Status ☐ Navar Marrie ☐ Widowed		Arme	Decedent Eve of Forces? (as 2 □ No s, Giva or Datas:	er in U,S. 1943 - 1946	13. Was Deceden If Yas, specify	t of Hispanic Origin Cuban, Maxican, P No Specify:	? (Specify Yes or Nuarto Rican, atc.)	O- 14. Rac Bla Specif	ce - American Ir ck, Whita, atc. y: WHIT	
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		Signature of Fur				ODDIA:		Addrass of Facility				P.A.,
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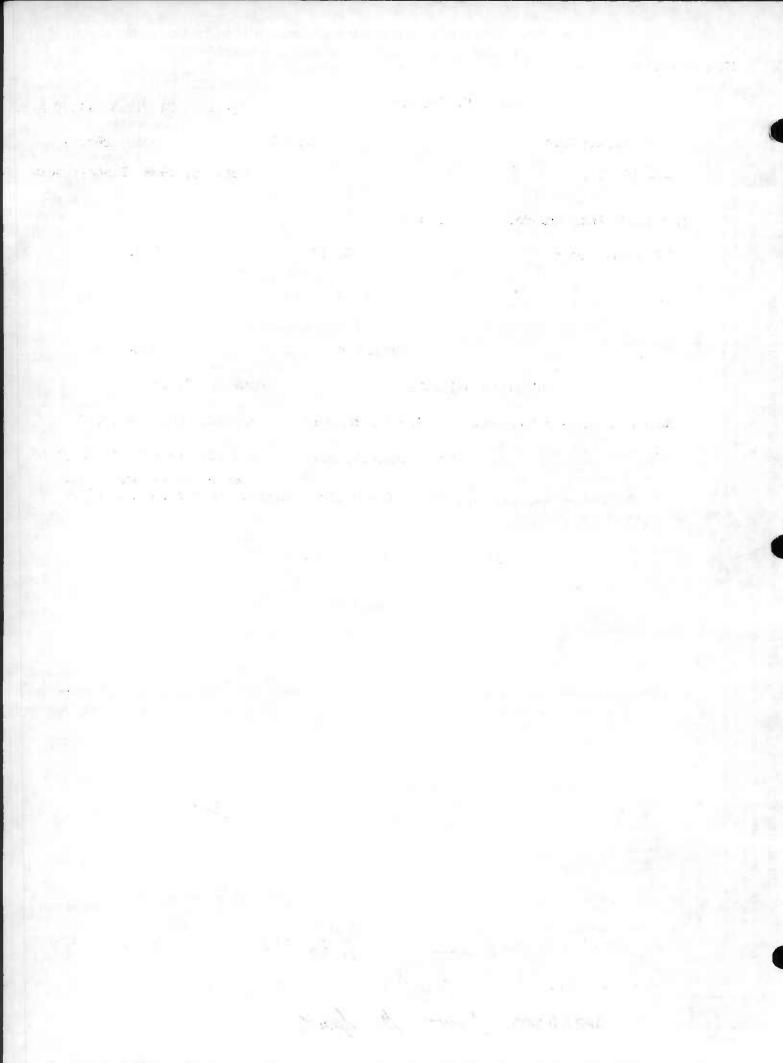
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: #24A PER MD G770 4-30-99 WR. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Alice B. Keating April 21 1999 11:20 A.M. * /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 132 Church Road Arno1d Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1□M 28 F 72 Yrs. 16, 158 14 3561 Pennsylvania Director Usual Residence of Decedent the Maryland r 28a-f show 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Directo Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7 is marked other than "natural", or items 23a or treumatic event, it a Medical Examiner must be r U.S. 21012 132 Church Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23, any Injury or other treumatic event, the Moulter Examples must Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - Americen Indian. Black, White, etc. Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondery (0-12) Own Home Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Giovanna Sanza Salvatore Bellante 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) Arnold, Maryland 21012 Karyn P. Volke / Daughter 132 Church Road 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4/27/99 Baltimore, Maryland Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 Franciscoph 23a. Perf1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and the burial-transit certificate be asscuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence ot): Box 68760. Physician/Medicai Due to (or es a consequence of): 88 esn signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, by 24b. Were autopsy tindings eveilable prior to Completed 24a. Wes an autopsy completion of ceuse of death? page 2 has 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) To Other: 4 Nursing Home 1 Yes 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28h Time of 28c. Injury et Work? Certification: After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death.

Funerel Director: A 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and manner es stated.

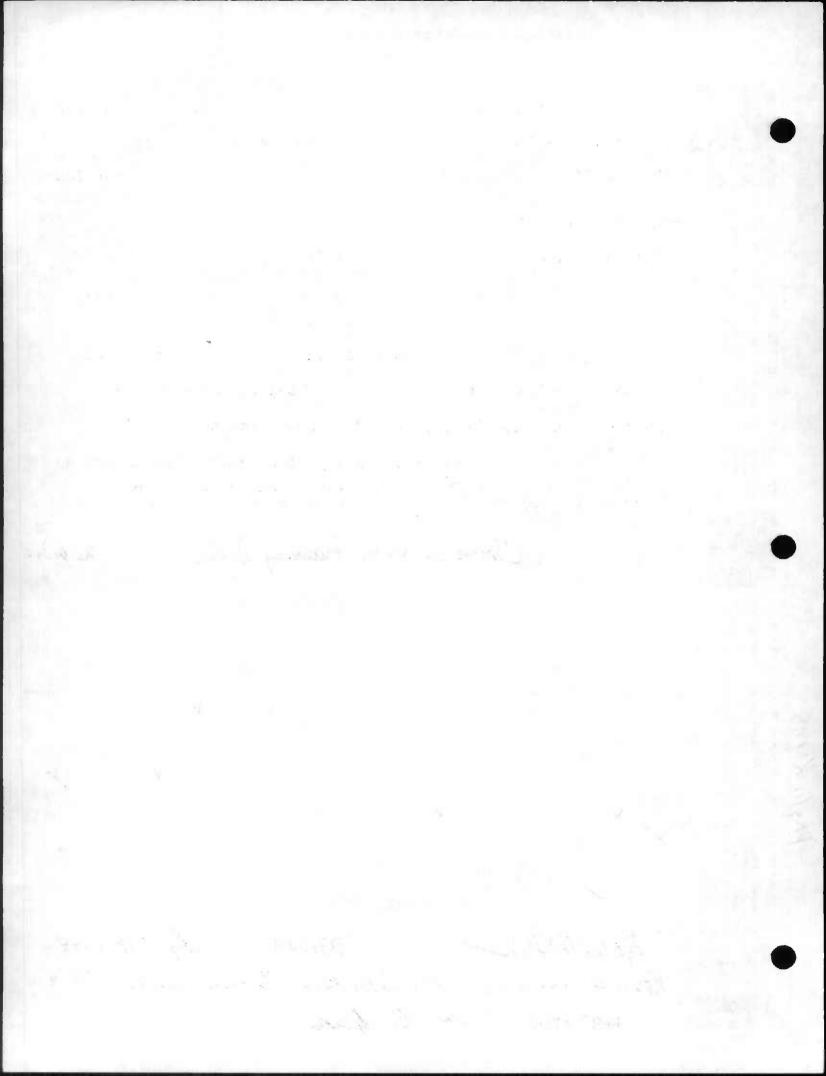
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner steted. 29a. Certitier Medical To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of geath (Item 23e) (Type, Print) S CrAIN HWY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Certificate o	f Death	Re	g. No.	14016			
A service	1. Decedent's Neme (First, Middle, La	st)			2. Dete of Deeth Month		3. Time of Deeth			
Physician /Medical	Phy1i	s Ann Kerns			April	27, 19				
Examiner	4e Fecllity Neme (If not institution, giv	e street and number)		4b. City, Town, or	Location of Deeth	4c. County of E	Deeth			
	St. Agnes Hos	pital		Baltim	ore	N/A				
Funeral	Sociel Security Number 6. S	0 1 1	Months Day			Year) 9.	Birthplece (State or Foreign Country)			
Director	216-36-0479	□M 280 F 59	Yrs.	, , , , , , , , , , , , , , , , , , , ,	July 8,		Maryland			
P	Usual Residence of Decedent	10.07.7								
aryla ahov	10a. Stete 10b. County		own or Location				10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
M Self	Maryland Balti	more	Arbı							
aryland 21215-0020 should be filed within 72 hours after death with the Maryland nd Martal Hygiene. marked other then "netural", or items 23s or 28s-f show unstice event, the Medical Exercitive must be notified at To Be. Completed by Finneral Director.	10e. Street end Number		10f. Zip Code		10	g. Citizen of Whe	t Country?			
23a 23a	1215 June Ro	ad		227			SA			
O iffer death w iffer man 23s	11. Marital Status	12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent o	of Hispanic Origin? (S uben, Mexican, Puer	Specify Yes or No- rto Rican, etc.)		American Indien, Vhite, etc.			
or if	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐XNo If Yes, Give	1□ Yes 2□N	lo Specify:		Specify:	White			
0020 nours s	3 ☐ Widowed 4 ☐ Divorced	Yeer or Dates:								
ind 21215-0 be filed within 72 ho tal Hygiena. I other then "netur avent, the Medical I Re Completed	15. Decedent's Ed (Specify only highest gre		Se. Decedent's Usual Occ (Give kind of work dor life. DO NOT use ret	cupation ne during most of wo	orking	6b. Kind of Busin	ass/Industry			
121	Elementary/Secondary (0-12)	College (1-4or 5+)			-	D				
C L Ser 1 and C C C C C C C C C C C C C C C C C C C	1 () 17. Fether's Name (First, Middle, Last,		Horse Tra		me (First, Middle, M	Race T	rack			
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ryla nould I Man arke	1		01- 44-33		sa Maria					
Maryland 21215-0020 d2 should be filed within 72 hours aff lith and Mental Hygiana. 77 is marked other than "natural", or traumatic avent, the Medical Energy To Re Completed by E	19a. Informent's Name/Reletionship (9b. Meiling Address (Stre							
Haalt	Angela Marie Woome	er/Granddaughter	1215 June	Road	Arbutus,	MD 21 0c. Location - City				
Or of H	1 Buriel 2 ACremetion 3	Removel from State ceme	tery, crematory or other p	plece)						
timen man jury	4 Donetion 5 Other (Specif		o Cremator							
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Mylana. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avant, the Modical Experience must be notified at once. To Re Completed by Finneral Director	21. Signeture of Funeral Service Licru	D. Com	Cremati	dress of Fecility	ety of M	D. Inc				
m vo = 2 a	Edward A. C	regorchik	299 Fre	ederick	Road Ba	ltimor	e, MD 21228			
	23a. Pert1. Enter the disease, or can shock, or heart failure. List only	Mcations that caused the deeth. Done cause on each line.	o not enter the mode of o	dying, such es cerdie	oc or respiretory erre	št,	Approximete Interval Between			
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/Medical	Immediate Cause (Final disease or condition	Chronic Oh	smetne 1	ulumary	Install		20 years			
Examiner	resulting in deeth)	Due to (or es	e consequence of):							
cute	Sequentially list conditions,	Due to (or es	e consequence of):							
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of Vital Records, Physician: The law requires th this cardificate has been signed and director, paga 2 should be do.	25. Wes case referred to medical			26. Plece of De	eath (Check only one	1)				
Vision of Vita Attending Physician: r death. setor: After this cartific by the funeral director. Hication: To Be	exeminer?	Hospitel: 1 ☐ Inpatient 2 ER/	Outpetient 3 DOA	Other: 4 Nursing	Home 5 Residen	nce 6 Other	(Specify)			
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Division or Attending after death. Director: After din by the fune entification	1 Natural 5 Pending 2 Accident Investigation	n		I ☐ Yes 2 ☐ No						
ViS Atte	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury - At home building, etc. (Specify)	farm, street, factory, office	ce	28f. Location (Str.	281. Location (Street and Number or Rural Route Number City or Town, State)				
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Division of Vital Re Division of Vital Re To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this cardificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29b. Signature and title of certified	1.	29c. Lice	ense number	29	d. Pate signed (Month, Dey, Year)			
	> KUUUUTEX	Mes	D	38543	/	Hm / 28	3,1999			
	30. Neme and address of person who	completed ceuse of deeth (Item 23	a) (Type, Print)			,	1			
4	KONIN H. SCH	uaas ms 90	O Custon A	venue Ba	Immore	Maylow	1 21229			
State	31. Date filed (Month, Day, Year)	32. Registrer's Signature		/	1		>			
Registrar	APR 3 0 19	99 Finera	A. Som	1/2/						
DHMH 16 Rev 6/95	- HINOVIS	1	- popular							



Ple

	Plea	se Type or State o	Print in I						-		275	ble.	14073
L				Ce	rtifical	te of	Death			Reg. N	lo.	De.	
1. Decedent's Nam EARL		e, Last) KATZENBERO	GER						2. Dete of De Month APRIL	eeth	Day 1999	9 Yeer	3. Time of Death 10:15pm
4e. Fecility Neme ((If not institution	, give street and nu	ım <i>ber)</i>				4b. City, To	wn, or L	ocetion of Dee		c. County		-
6 Coo1	l Breeze	Drive					Midd	ile I	River		Ba1t	timor	e
5. Sociel Security N 220–68–0	0174	6. Sex 1 → M 2 □ F	7. Age (In yrs. 41		Months	Deys		24 Hrs. Min.	8. Dete of Bi June 2	inth Yea		9. Birthp	plece (Stete or Foreign
Usual Rasidence o 10e. Stete	of Decedent 10b. County		10c. C	ity, Town or Lo	ocation								10d topido City Limite
Md.	Ba1	ltimore	100. 0.	ty, rount or 2.				1	Middle				10d. tnside City Limits 1 ☐ Yes 2 ☑ No
10e. Street end Nu	umber urke Roa	ad				p Code 212	20			10g. C	USA	Whet Cour	ntry?
11. Marital Status 1 Never Marr 3 Widowed	ried 2 Marrie	Armed Fo	20XNo		Wes Deced If Yes, spec 1 \(\text{Yes} \)	ecify Cub	ben, Mexican	n, Puerto	pecify Yes or No Rican, etc.)	0-		ck, White,	can Indian, , etc.
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Carpenter Carpenter													
17. Fether's Neme		Last) atzenberge	er		ponoc	-			ne (First, Middle				0.12011
19a. Informent's N				19b. Mail	ing Addras	s (Stree			rel Route Numb	ber, City	or Town,	, State, Zij	p Code)
Sandra H	Harrah /	'sister		15	12 Bu	ırke	Road	Ba	altimor	e Ma	aryla	and 2	1220
	_	3 □Removel from pecify)	State	Place of Dispo cometary, cred fetro C	emetory or o	other ple			Dete	20c. L	Location -		own, Stete
21. Signature of Fu	Tiru	y Conn	elly	2	22. Name en CO 30	onnel OO M	ess of Fecility 11y Fu Ace AV	nera Te. H	al Home Baltimo	of ore M	Esse	ex.	Q.
Immediate Ceuse	(Finel	complications that copy one cause on e	saused the defe	th Do not en	nter the mod	de of dyi	ring, such es	cerdiec	or respiretory	errest,	4		Approximete Intervet Batween Onset end Deeth
diseese or condition rasulting in daath)	n	е. О	Due to (or as e conse	quance of):	-3-	N. VVV	7 4 4 4 4	10			1	
Sequentially tist co if eny, leading to in cause. Enter Under	mmediate leriving	b	Due to (c	or as a consec	quence of):	:							
Causa (Disaasa or thet initieted evants resulting in death)	ls	d	Due to (c	or es e consec	quence of):								
Part It. Other elgnif	0.	ne contributing to de		sulting in the u	underlying c	gi	iven In Part I.				o use coi		to the cause of death?
Q									24a. Was	s en eute formed?		ev	Vare autopsy findings veileble prior to completion of cause
									1 🗆	Yes a	2 No	of	death?
25. Was case refer examiner?		Hospitel:				01	thor:		th (Check only		~/		HOME OF
27. Mannar of Deet 1 Natural 2 Accident	5 Pending investiga	28e. Data (Moni		28b. Tima o Injury		28c. tnju Wo	4 🗆 1901		ome 5 Res 28d. Describe		-	ner <i>(Specif</i> rred d	MACQUAINTANCE
Suicide 4 Homicida	6 Could no determin	nad 286. Piece buildi	e of tnjury - At hi ling, etc. (Spacit	ome, farm, st	reat, factory	y, office			28f. Location (City or To	own, Ster	ete)		alfo Md 2 (22)

To the Hospital or Attending Physician: The law requires that the death certificate be executed ettending physician and for use es the buriel-trensit Division of Vital Records, P.O. Box 68760, been signed by the e should be detached f director,

After this

within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral of

Physician

/Medical Examiner

Physician

/Medical

Examiner

Director

Be Completed by Funeral

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in a Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Be Completed by Medical Certification: To

6 Cook Bruge UC. Halto

29a. Cartifier

1 Certifying Physicten: To the best of my knowledge, death occurred et the time, deta and place, end due to the causa(s) end menner es steted.

2 Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end manner stated.

29b. Signature end title of certifier

29c. License number

29d. Date signed (Month, Dey, Yeer)

April 26, 1999 J. Custlen Monora, M.D. DO 7632 April 26, 1999

30. Name end eddress of person wife completed cause of deeth (Itam 23e) (Type, Print)
J. CROSSAN O'HONOVAN, MD., 2112 DUNDALK AVE., BALTO MD 21222

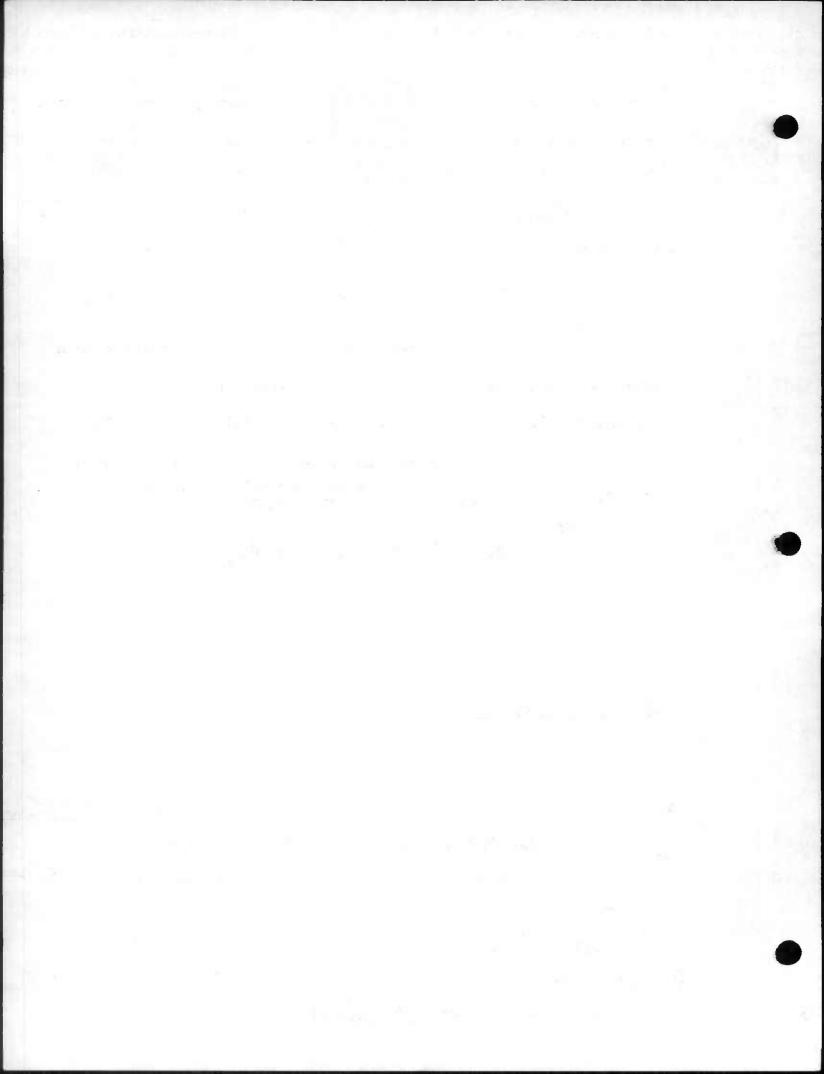
31. Detailed (Month Day York)

31. Date filed (Month, Day, Year) State

APR 3 0 1999



Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dev Yee **Physician** 12:524 4 99 29 KARKAUSKAS MYRTLE /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ex 17. Age (In yrs. last birthday) If Under 1 Yea UNIVERSITY 94 If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 10 M 200 F 88 Director Maryland 8/12/10 219-12-9144 Usual Residence of Decedent the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Medical Experimenment be notified at Md. n/a 1 Yes 2 No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1611 Harden Court 21230 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck White etc. Pages 1 and 2 should be filed within 72 hours after on not of Health and Mental Hygiena. nnt: If Item 27 is marked other than "natural", or Item 1 ☐ Yes 2 No 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ₩ Widowed 4 Divorced white Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Sacondary (0-12) College (1-4or 5+) Factory Worker Match Box Company 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Clarence Norton Hildegarde Rowan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sherry D. Hogan (Granddaughter) 1516 Patapsco Street, Baltimore, Md. 21230 other 1 Baltimore. 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) or 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Green Mount Cemetery 4/30/99 Baltimore, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest,

Approximately a complication of the cause of the death. Do not enter the mode of dying, such as cerdiac or respiratory errest,

Approximately a complication of the cause of t **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) . NON-SMALL CELL Examiner Due to (or as a consequence of): Examiner ician end buriel-transit CHROLIC OBSTRUCTIVE SAMONAEL DISKASE Sequantially list conditions, if any, leading to immediate ceuse. Entar Undarlying Causa (Disaasa or injury that Initiated events resulting in daath) Last Dua to (or as a consequence of) Physician/Medicai the Due to (or as a consequence of) 88 for use as 23b. Dld tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. ed by th 1 Yes 2 No 3 Probably 4 Unknown ped ped b Records, þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Completed peen performed page 2 s 2 N No 1 ☐ Yes 1 ☐ Yes 2 No certificate Division of Vital funaral director, 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) L_o 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After Hospital or Attanding 1 Natural 5 Panding efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e 1 Certifying Phyaician: To the best of my knowladga, daath occurred at tha tima, date and place, and due to the causa(s) and mannar as stated.
2 Medicat Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier To the Vithin 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 155114 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. GREENE ST. BAUTHORE E. MARUEN 22 THOMAS M.D.

32. Registrar's Signature

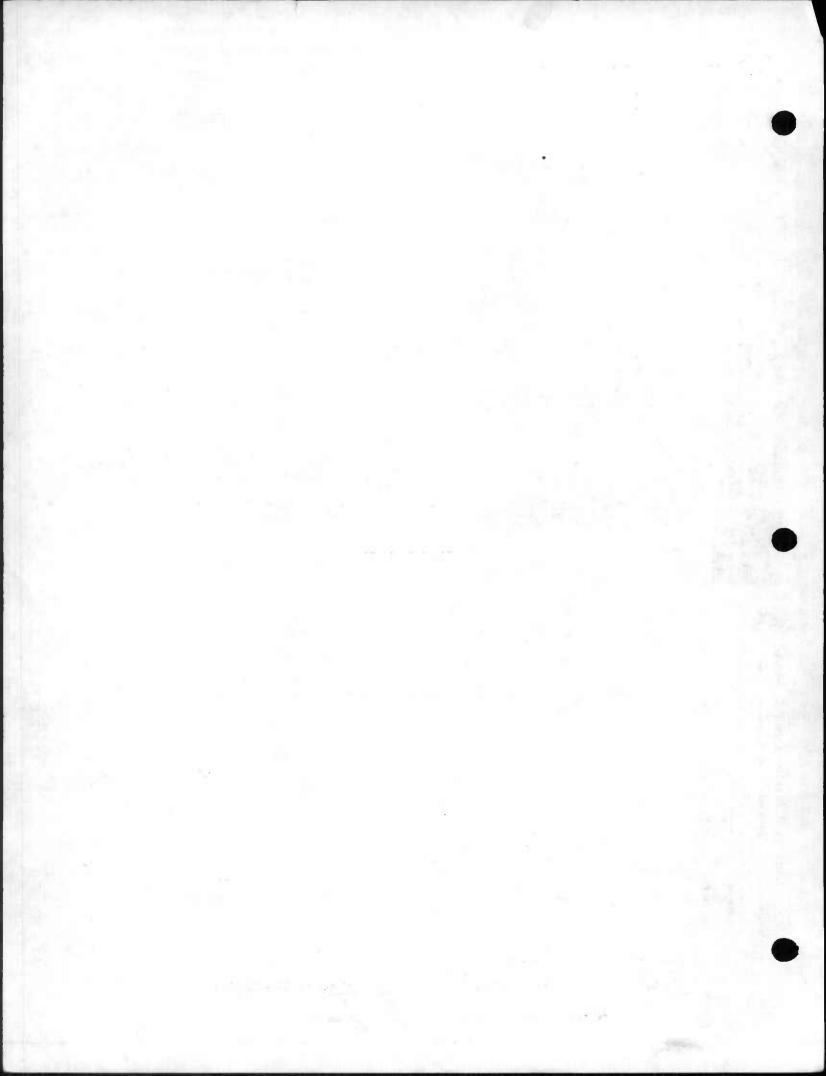
Registrar **DHMH 16 Rev 6/95**

State

31. Date filed (Month, Day, Year)

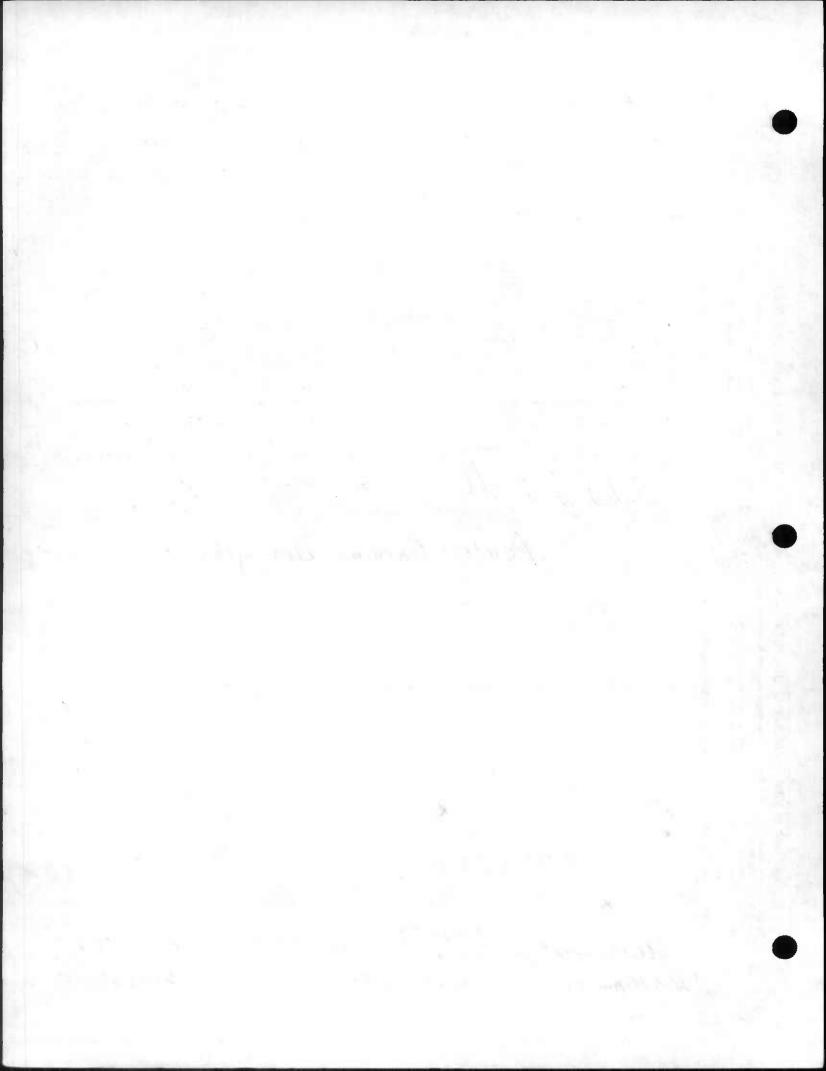
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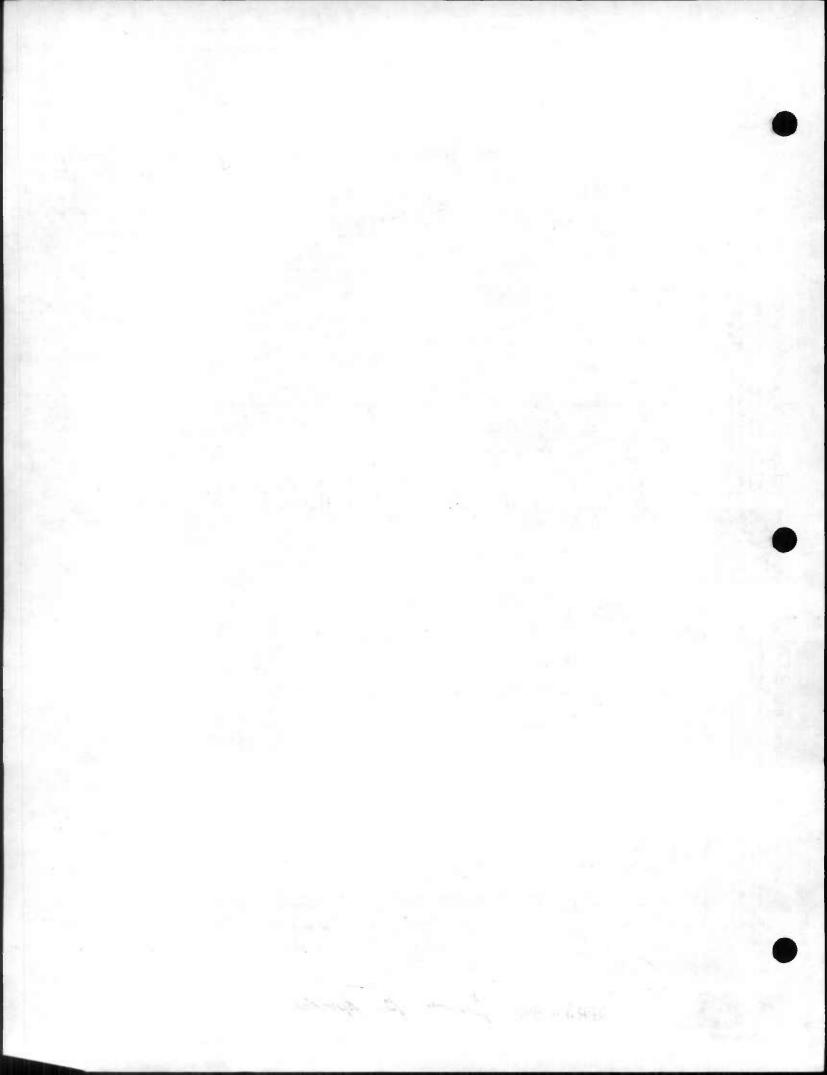
State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Cobert Luther Lively April 25 1999 0920 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 17 M 2□ F 55 233-68-9799 Yrs. Director Sept. 11,1943 West Virginia Usuel Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location "natural", or Itema 23a or 28a-f ahow 10d. Inside City Limits XXYes 2□No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 2175 Glenfield Road 21401 USA death v Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after ant of Health and Mental Hygiene. At if Itam 27 is marked other than "natural", or he ary or other traumate avant, the Menical Empiries 1 ☐ Yes 2 X No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 Married aitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Security Analyst T. Rowe Price 12 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Luther Lively 2 Mildred Woolridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gathalee F. Lively (Wife) 2175 Glenfield Road, Annapolis, MD 21401 20b. Plece of Disposition (Name of cematery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1√2 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or page. Lakemont Memorial Gardens 04/28 Davidsonville, MD 21. Signature of Euperal Service Licensee 22. Name and Address of Fecility Hardesty Funeral Home, P.A. Urrele 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final Irrhythmia MINUTES disease or condition resulting in death) Examiner Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): physician a Box 68760, Physician/Medical Dua to (or as e consequence of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? should Completed pege 2 s has 1 Yes 2 ONO 1 ☐ Yes 2 ☐ No certificate Division of Vitai or Attanding Physician: funeral director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Netural 5 Pending deeth. To the Hospital or Attandit within 24 hours after death. To the Funeral Director: A completely filled in by that it investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Plece of Injury - At home, Ierm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as steted.

2 Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted. Medical 29a, Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture and title of certifier Deputy D06054 m ed cause of deeth (Item 23a) (Type, Print) 30. Nema and address of person who come JONES, MO 1,1/1Am 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State 1999 APR 30 Registrar



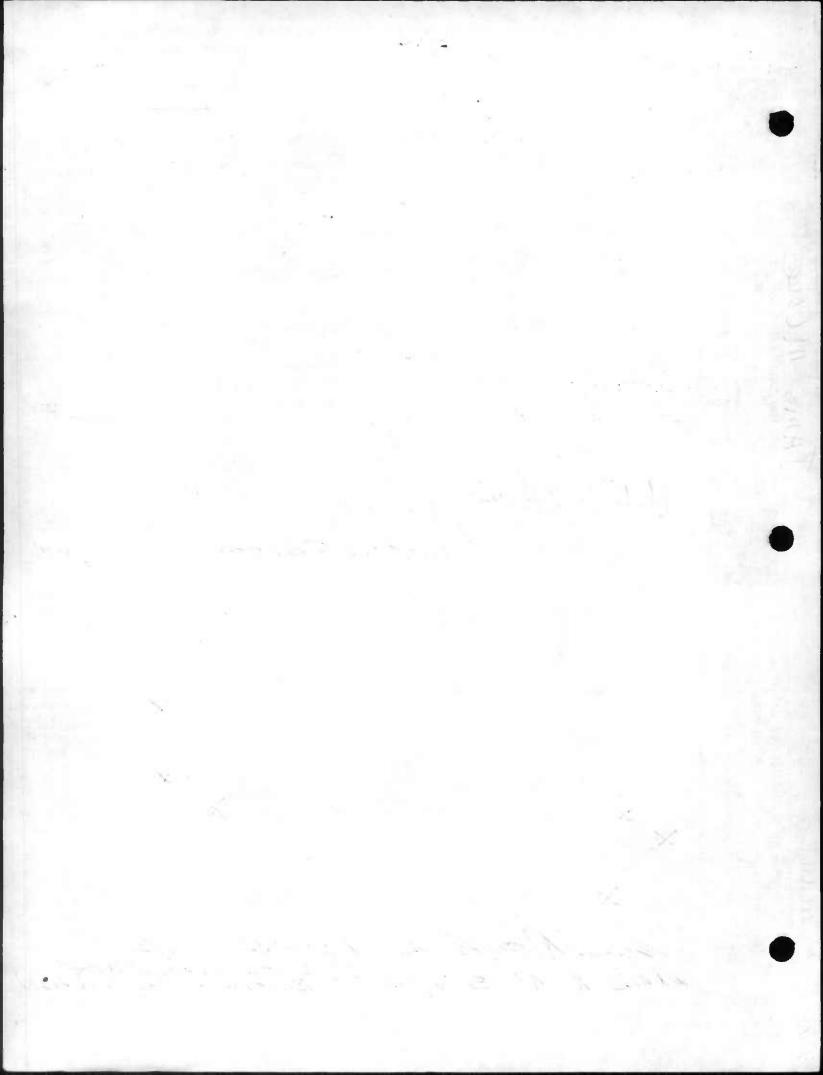
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IIVIII MCC	лау			Certificat	e of Death	F	leg. No.	1407	1
Phys	ician	1. Decedent's Name (First, Middle, L	ast) Mada			2. Date of Dea Month	Day	3. Time of	
/Me	dical	4a Facility Name (If not institution, g	H, MICCI	ay	4h City Town o	April.	24, 1999 4c. County	200	P.M.
Exan	niner	3101 Swan Drive	ve sueet and number)	-	Baltimor		N/Z		
Funera	al		Sex. 7. Age (In yrs.	. last birthday) If Under Months	1 Year If Under 24 Hr	s. 8. Dete of Birth		9. Birthplace (State of ACeluntry)	r Foreign
Directo		Usual Residence of Decedent	10 M 20 F 42	Yrs.	Days Hours Mil	Julyta	7956	Marylo	ind
Mend wor		10a. State 10b. County	/ A 10c. C	ity, Town or Location				10d. Inside Cit	ty Limits
Men	otor	Maryland N	IA	Baltin	ore			1)X Yes	2□No
after deeth with the Menyler or ferms 23s or 28s-f show miner must be notified at	Director	10e. Street and Number	1/1/01	10f. Zig	Code		log. Citizen of V	Vhat Country?	
23e		2110 MT. 1	tolly St.	12 Was Dage	1216	Specify Vec or No.	U.	S H e - American Indian,	
flar d	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Direction Ever in L Armed Forces? 1 Yes 2 No	If Yes, spe	dent of Hispanic Origin? (cify Cuban, Mexican, Pue	rto Rican, etc.)		k, White, etc.	
OUTR PARTY.	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 Yes	2 No Specify:		Applicity	ican Amer	rican
21215-0020 d within 72 hours after deeth with the Menyland glens. pr than "natural", or hams 23s or 28s-f show in the Medical Examiner must be notified at	Completed	15. Decedent's I (Specify only highest g		16a. Decedent's Usu (Give kind of wo	al Occupation ork done during most of w se retired)	orking	16b. Kind of Bu	siness/Industry	
212 3 vithir plene.	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	Maintain	nce Work	for	Diolom	at Contami	inium
	800	17. Father's Name (First, Middle, Las	1)	1. WITTEHA	100	ame (First, Middle,	Maiden Sumam		THU WE
N Para	To	Martin M	ccray Sr	1	IVIa	rion :	J. Sn	rith	
Mar d 2 sh sh end 7 ls m traum		19a. Informant's Name/Relationship	(Type, Print) (Sister	19b. Mailing Address	S (Street and Number or F	Rural Route Numbe	r, City or Town,	State, Zip Code)	1/.
re, N 1 and 1 Health 1 Health 1 other tr		20a. Method of Disposition	20b.	Place of Disposition (Na	me of	Date	20c. Location -	City or Town, State	0
0 40+ 5		1 Burial 2 Cremation 3	THemoval from 2016	cametary, crematory or o	uner place)	5/1/99	Lanso	towne. I	Md.
Baitim pemit. Pag Department Important: I		21. Signature of Funeral Service/Lice	insee D. D	22. Name ar	nd Address of Facility	c Eun	0 00 1 1	Unmo	1-1-1
m 22F2	8	Joseph	J. Kus	1 2222	W. North	ve. Ba	to. Ma	.21216	
4.		23a. Part1. Enter the disease, or con shock or heart failure. List only	nplications that caused the dea y one cause on each line.	th. Do not enter the mod	de of dying, such as cardi	ac or respiratory en	rest,	Approximate Interval Beh Onset and I	ween
Physicia: /Medica		Immediate Cause (Final						Onset and t	Joann
Examine	r	disease or condition resulting in death)	a. Drowning	or as a consequence of):				1	
2 =	in in								
68760, tificate be executed ig physicien end as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):					
68760, fileate be ax a physicien as the burial	edical E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C. Due to /	or as a consequence of):					
(68760, rifficate be executed ng physicien end as the burial-transit		resulting in death) Last	D00 10 (1	or as a consequence ory.					
BOX est on intendi	Physician/M		d					1	
. 0 . 0	ysic	Part II. Other significant conditions	contributing to death but not re-	sulting in the underlying o	ause given in Pert I.			ntribute to the cause of	
De dete	by Ph			15		. 101	es 2 No	3 Probably 4	Unknown
U = 0	P					24a. Wes i	an eutopsy med?	24b. Were eutopsy f available prior t	indings
Ø ≥ ± 00	Completed					portor		completion of c of death?	ause
- F # ā	Con					¥D Y	es 2 No	ty∑Yes 2□	No
Of Vital I Physicien: The rthis certificate and director, pe	8	25. Was case referred to medical examiner?	Hospital:		0.0	eath (Check only o			
P d sign	2	1 ☑ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 3□ D0	DA 4 Nursing 28c. Injury at Work?	Home 5 ☐ Resid	ence 6 [X]Otho ow injury occurr	er (Specify) at so red Subject v	cene
VISION O Attanding Ph r death. ector: After th by the funeral	atio	1 Natural 5 Pending 2 Accident investigati	01 21 1000	3:46 P M	Work? 1☐ Yes 2∏No			omerged sel	
Division or Attending s after death. I Director: Afte d in by the fune	Certification:	3 Suicide 6 Could not determine	building, etc. (Speci	ify)		281. Location (S City or Tow	treet and Numb n, State) 31(er or Rural Route Num 01 Swan Dri	ber, LVe,
DIVIS To the Hospital or Atta within 24 hours stee de To the Funeral Directo completely filled in by th		29a. Certifier 1☐ Certifying P	Druid Park I			Baltimo	re, Mary	land.	
e Hos 124 ho Fun Metely	edical		miner: On the basis of examination and manner stated.	ation and/or investigation	in my opinion, death occ	curred at the time, o	late and place,	and due to the cause(s	i)
¥lthir To th	X	200. Signature and title of certifier	11 5	29	c. License number		29d. Date signed	d (Month, Day, Year)	
		14 Vector	u, M.D.		O.C.M.E.		April 2	25, 1999	
14		30, Name and address of person who	completed cause of death (Ite		L Penn Stree	t Raltin	nore M	arcal and 21	201
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign			r, parti	INTE, PR	TYTORU ZIZ	201
Regis		APR 3	1999	p. 1	sports				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item #2 PER DR.G-771.5/19/99dhb Item#19b per Infor G771 5/4/99 gap Certificate of Death Reg. No. 2. Dete of Deeth 4-28-99 Month Day 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** 4:45pm JAMES MOORE /Medical 4a Facility Name (If not institution, give street end number) 4b_City, Town, or Location of Death 4c. County of Deeth Examiner 4538 RUD KU GERS DAUTO If Under 24 Hrs. If Under 1 Yaar 8. Deta of Birth (Month, Day, Y 9 – 22 – 23 5. Sociel Security Number 7. Aga (In yrs. lest birthday) 9. Birthplace (Stete or Foreign **Funeral** Months Days 1₩ 2□ F Hours 75 BALTO, MD Director 216-14-7390 10a State 10b. County 10c. City. Town or Location 10d. tnside City Limits Yes 2 No Directo N/A BALTIMORE 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 4538 N. ROGERS AVE 21215 U.S.A. 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yas 2 No
If Yes, Give Black, White, etc. 1 Never Merried 20 Married 1 Yes 2 No Specify: BLACK Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 social security GOVERNMENT d 2 should be filed v th and Mental Hygie 7 is marked other t 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fathar's Neme (First, Middle, Last) Be FLEMING MOORE LULA DICKSON" 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) LILLY MOORE (WIFE) 4538 N. ROGERS AVE, BALTO. MD -21207 mportant: If Nem 27 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 5-3-99 BALTO. MD LOUDON PK CEMETERY 22. Name end Address of Fecility Funeral Service Licensee LEROY O DYETT & SON FUNERAL HOME 4600 LIBERTY HGHTS AVE. BALTO. MD 21207 Part1. Enter the disease, or complications that caused in shock, or heert feilure. List only one ceuse on each line. Approximete tnterval Between Onset end Death Do not enter the mode of dying, such as cerdiac or respiratory errest, **Physician** Gastrie Cancer /Medical Immediate Cause (Finel disaase or condition resulting in death) Examiner physician end s the burial-trensit Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yea No 3 Probably 4 Unknown signed b by 24b. Were eutopsy findings eveilable prior to Completed 24a. Wes en eutopsy performed? completion of cause of deeth? 1 Yes MNo 1 ☐ Yes 2 ☐ No certificate of Vital 25. Wes case rafarred to medicat examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Nesidence 6 □Othar (Specify) 1□ Yes 2 No Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28h Time of 28d. Describe how injury occurred 28c. Injury et Work? Neturel 2 Accident Division Attending 5 Pending investigation death. 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 5 24 hours Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner es stated.

Medical Examiner: On the basis of examinetion and/or Investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end memory stated. 29e. Certifier To the Fune completely f (Check only one) within 2. 29c. License number 29d. Date sigged (Month, Dey, Year) ed ceuse of death (Item 23a) (Type, Print) Ex Horno 31. Dete filed (Month, Dey, Year) State APR 3 0 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month Frederick John Mestl 28, April 1999 2:15 PM 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore If Under 1 Yaar | If Under 24 Hrs. 6. Sax 1 M 2 F 8. Data of Birth (Month, Day, Jan. 4, 9. Birthplaca (Stata or Foreign Country)
Maryland 5. Social Sacurity Number 7. Aga (In yrs. last birthdey) Hours Months 60 Yrs. 220-34-6543 Usual Rasidenca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Baltimore Lutherville 10a. Street and Number 10g. Citizen of What Country? 10f. Zin Code 1703 Haddington Garth 21093 U.S.A. 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Meritel Stefus 1 Never Married 2 Married ☐ Yas 2 XNo f Yas, Giva 1 ☐ Yas 2 X No Specify: White. Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) Delivery Truck Driver Furniture Store 10th Grade 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Frederick Max Mestl Katherine B. Gerst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Code) Marge Fraley 1703 Haddington Garth, Lutherville, MD (niece) 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, State 1 ₺ Burial 2 Cremation 3 Ramoval from 566 Bel Air Memorial Gardens 4/30/99 Bel Air, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility
Schimunek Funeral Home, Inc. 21. Signatura of Funeral Se vice Licensee 9705 Belair Rd., Baltimore, MD 23a. Part 1. Enter tha diseesa or complications that caused tha daeth. Do not entar tha mode of dying, such as cardiac or raspiratory errast, shock, or haart failura. List only ona causa on each lina. Approximeta Intarval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting in deeth) Colon Cancer Due to (or as a consequanca of). Sequentially list conditions, if any, laading to immadiate causa. Entar Undarlying Cause (Diseese or Injury that initieted evants rasulting in death) Last Dua to (or as a consequence of): Due to (or as e consequance of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings aveilable prior to complation of cause of death? 24a. Was an eutopsy performed? 1 Yas 2 No 1 Yes 2 No 25. Wes casa rafarred to medical axaminer? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 NOther (Specify) HOSPICE 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mennar of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Dascribe how injury occurred 28b. Tima of 1 XNatural 5 Panding invastigation

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or 28s-f show

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5-0020 S

Baltimore, Maryland 2121

Pages 1 and 2 should be reportant: If Item 27 is marked

Health

2:1

1999

Director

Funeral

by

Completed

Be

Examine edicai Certification: To

Frederick Mestle Records, P.O. Box 68760, Division of Vital a 24 hours after of Funeral Direct ò

Physician/Medical by Completed Be

State Registrar

APR 3 0 1998

6 Could not be detarmined

2 Accident

3 Suicida

29a. Certifiar

4 Homicida

(Check only one)

29b. Signatura and tifla of certitian

29c. License number 43721

1 ☐ Yas 2 ☐ No

2 Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 20/99

Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

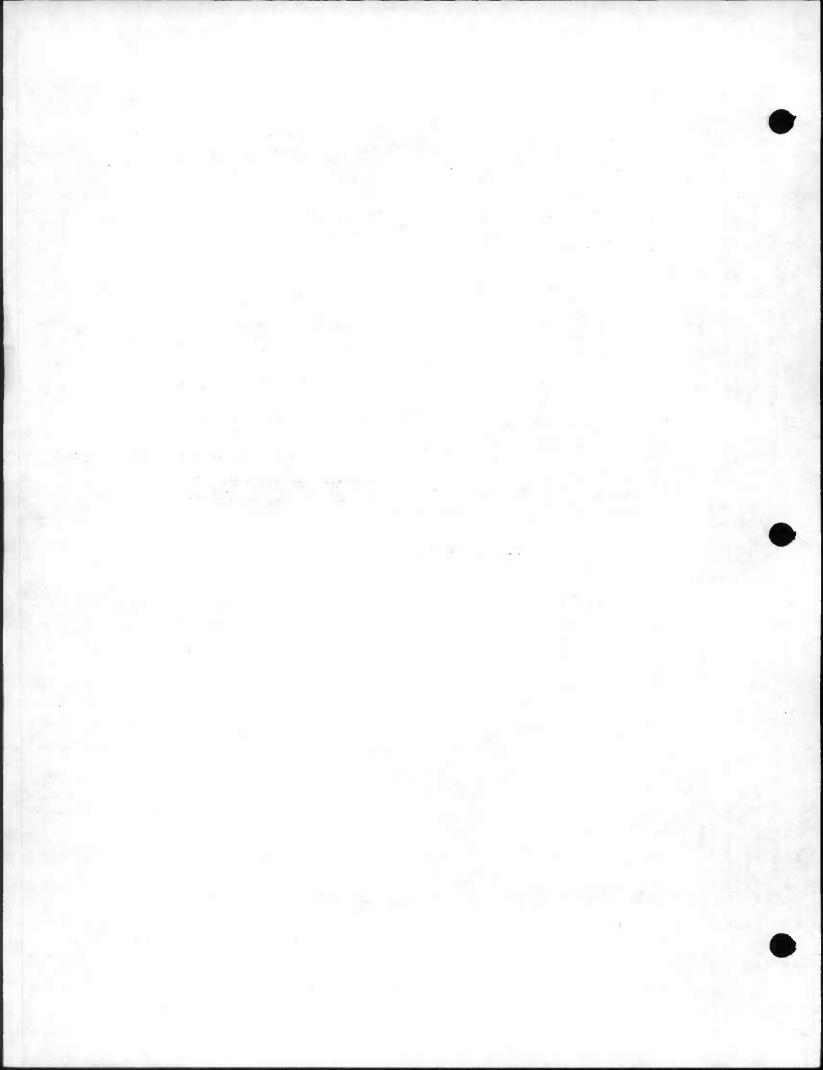
2300 Dulaney Valley Rd., Timonium, MD 21093 Tarig Mahmood, 31. Date filed (Month, Day, Year)

32/ Registrer's Signatura

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

1 Xcertifying Phyeician: To tha best of my knowledge, deafh occurred af tha tima, date end place, and dua to the causa(s) end mannar es stated.

To the To To the F



JOSEPH MCC RACKEN re, Maryland 21215-0020

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 6:47PM Joseph I. McCracken /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ACOUNT 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) Funeral 10 M 20 F Months Devs Hours 183-34-7984 Director 57 Pennsylvania Nov. Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Millersville 1 ☐ Yes 2 No Director 'natural', or itsms 23s or 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Route 3 North 21108 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? WXYes 2 □ No IYes, Give Yeer or Detes: 1960–64 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Plumber Plumbing 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be and Mental Olen McCracken Elma Etta Conrard Pages 1 and 2 should 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) mportant: If item 27 is Sallie McCracken (Wife) 601 Route 3 North, Millersville, MD 21108 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1

Burial 2 □ Cremetion 3 □ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial Carden 04/30 Davidsonville, MD 21. Signeture of Euneral/Service Licensee 22. Name end Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the disease of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heer failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest and Due to (or es e consequence of): Box 68760, Physician/Medical the Due to (or es e consequence of) P.O. 1 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy page 2 s 1 Yes 2 No certificate Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 □ DOA Division of 28c. Injury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, Iarm, street, lactory, office building, etc. (Specify) 28I. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide within 24 hours at To the Funeral D completely filled Medical Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier To the 29b. Signature and mine of confine 29c. License number 29d. Date signed (Month, Day, Year, 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Rooid Bringman WI 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

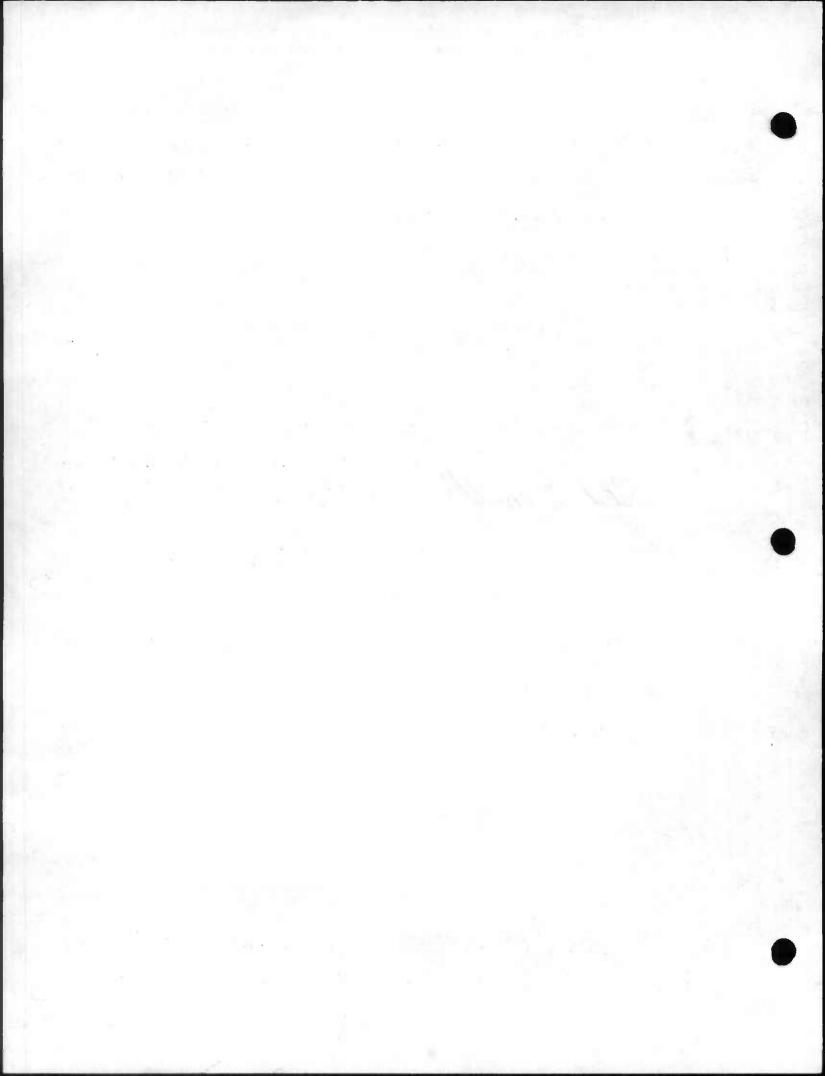
State of Maryland / Department of Health and Mental Hygiene

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Registrar

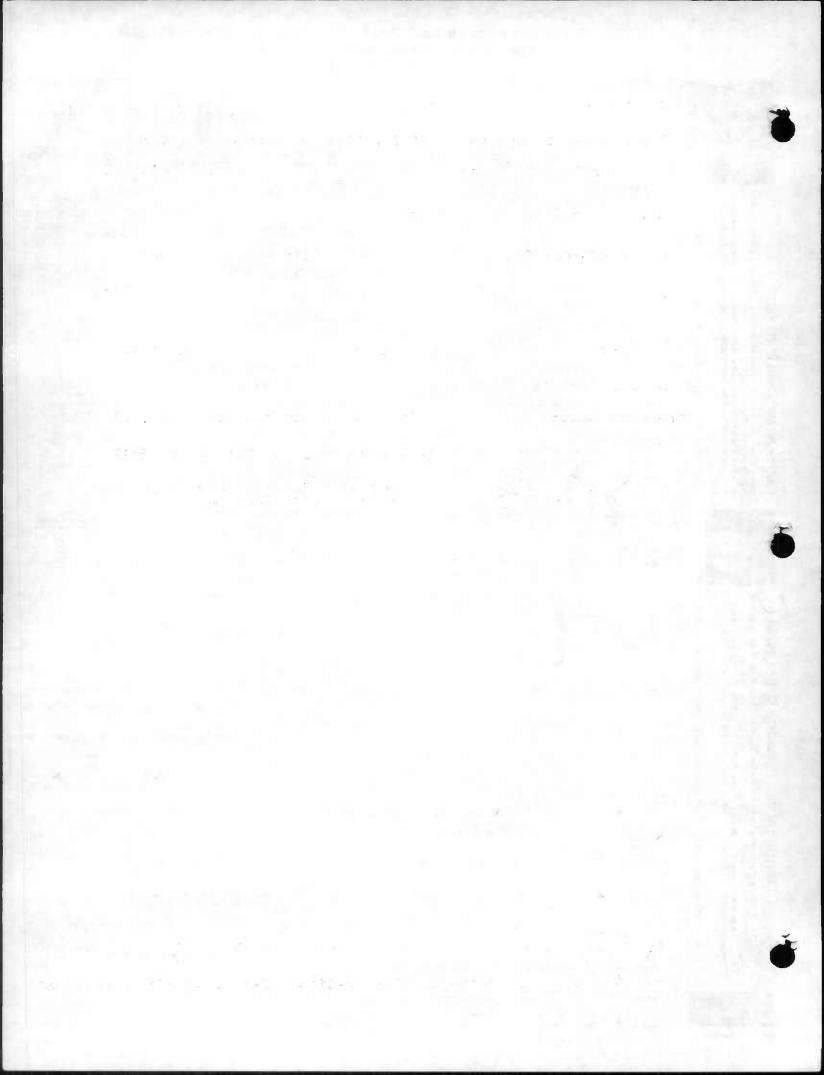
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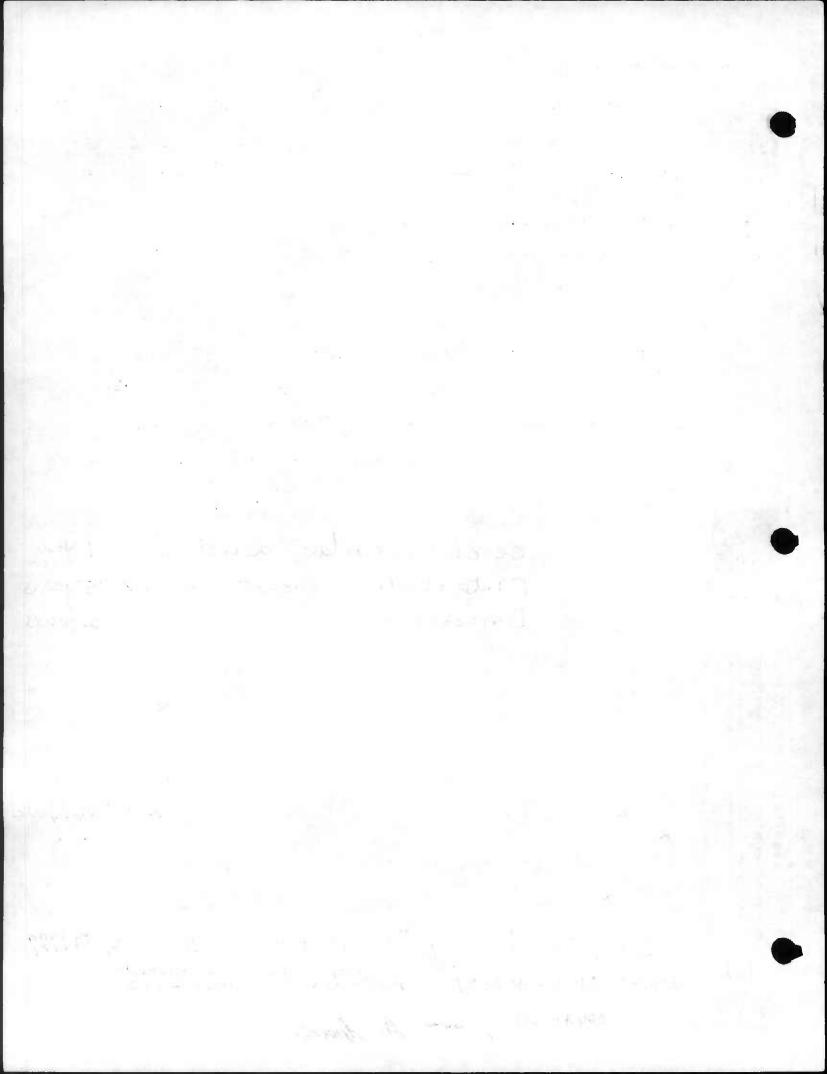
State of Maryland /	Department	of Health and Mental	Hygiene (
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		State of Ma	aryland		artmen			and M		giene 9 9		180:	
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/Medical Examiner	4e Fecility Neme (If not institution, giv	e street end number)				4	b. City, To	wn, or Lo	cation of Deeth	4c. County		17.00	
Examiner	Johns Hopkins	Bayview	Med	lical	Cent	er	Bal	tim		N/A			
Funeral Director	5. Social Security Number 6. S 218-18-8551	- · · · · · · · · · · · · · · · · · · ·	e (In yrs. k	est birthday) Yrs.	If Under Months	1 Year Deys	If Under	24 Hrs. Min.	8. Date of Birth (Month, Dev Jan. 27	, 1910	9. Birthple Count Md.	ece (State or Fo	oreigi
P .	Usuel Residence of Decedent		100 City	, Town or Lo	antion						10	d. Inside City L	imite
should be filed within 72 hours after death with the Maryland and Mantle Hyglene. marked other than "ratural", or items 23a or 28a-f show marked other than "ratural", or items 23a or 28a-f show unstice event, in what call Exercitive mans be notified at to Be Completed by Funeral Director	Md. Balt	imore		owson	Catton						10	1 ☐ Yes 2	
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tal hygiene. d other than "natural", or items 23a or 28a-f si event, the Medical Experiment mant be notified event, the Medical Experiment properties. Be Completed by Funeral Director	11. Maritel Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No H Yes, Give Yeer or Detes:			if Yes, spec		Specify:	, Puerto	Rican, etc.)	Bled	, White, e	tc.	
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within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (1 Maturel 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Da	y Year)	Injury	М		k? Yes 2□	No		Street end Numb		l Route Number	r
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1. Decedent's Name (First, Middle,	EW		Certificate	e of L	Death			Reg. No.	1.1	:1182
	Last)					1	2. Dete of De Month	eth Dey	Yeer	3. Time of Death
ical	A. Mattisz						April	27, 1999	9	11:15 P.M
iner 4e Facility Name (If not institution,				4	b. City, To	wn, or Loca	ation of Deetl	4c. County	of Deeth	
Hospice Of The		(In yrs. last birti	hdev) If Under	1 Year	Lint	hicur	n Dete of Ric		Arur	
218-18-3665			rs. Months	Days	Hours	Min.	B. Dete of Bir (Month, De	13,1924		lace (State or Foreign try) ryland
Usuel Residence of Decedent		13					Jept.	13,1324	Picti	Lylana
10a. Stete 10b. County		10c. City, Town	or Location						10	Od. Inside City Limits
2	Arundel	Pasa	adena							1 ☐ Yes 2 Mo
			10f. Zip					10g. Citizan of W		try?
219 Magothy Bea	12. Was Decedent E	iver in U.S.		2112		nin? (Spec	ity Yee or No		e - America	an Indian
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15. Decedent's (Specify only highest Elementary/Secondary (0-12)	College (1-4or 5-		lifa. DO NOT use	e retired))	OF WORKING	,	13		
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Frank Mattisz (H			19 Magotl							
20e. Method of Disposition	iusbaria)	20h Place of	Disposition (Nem	e of		1100.	Date	20c. Location -		
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ORIGINAL



WRC 99-2309-510 ROBERT

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State of Maryland / Department of Health and Mental Hygiene 99 4983

ORSELL			Certificate	of Death	Reg	. No.	1,000				
STATE OF THE PARTY	1. Decedent's Name (First, Middle, La	(51)	11	-1.1	2. Date of Death Month		3. Time of Death				
Physician /Medical	'KODER	T E	MORSE			Day Year 21, 1999	3:40 PM.				
Examiner	4a Facility Name (If not institution, give	· · · · · · · · · · · · · · · · · · ·		4b. City, Town, or		4c. County of Dea					
184	2531 W. LANVAL			BALT		NA					
Funeral Director	5. Social Security Number 6. S 216-09-5840 Usual Residence of Decedent	7. Age (In yrs.	last birthday) If Under 1 Yrs. Months	Year If Under 24 Hrs Days Hours Min.		99. Bir	thplace (State or Foreign ountry)				
ahow	10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits				
the Man 28s-fah nottried	MD NA		BALTIMO	PE			1 TYes 2 □ No				
fier death with the Menyland from 23s or 28s-f show from must be notified at Funeral Director	10e. Street and Number	LANVALE	10t. Zip C	21216	10g	. Citizen of What Co	ountry?				
	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decede	nt of Hispanic Origin? (S y Cuban, Mexican, Puer	Specify Yes or No-	cify Yes or No- 14. Race - American Indian,					
020 Ura by	3 Widowed 4 □ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2	/	to Rican, etc.)	Rican, etc.) Black, White, etc. Specify: A FRICAN A MERICAN					
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CA BER	Elementary/Secondary (0-12)	College (1-4or 5+)	tile. DO NOT use	retired)	/	7 -	Tare				
	17. Father's Name (First, Middle, Last		OFTE	18 Mother's Na	me (First, Middle, Ma	iden Sumama)	liows				
E SESS W		Morsell		Lon	a To	won.					
laryia	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or R	urat Route Number, C	city or Town, State,	Zip Code)				
CHNL	LARRY GALBRE		4 RANDAL	1 - 0		MI) 2/2					
of Healt from 2	20a. Method of Disposition	20b. F	Place of Disposition (Name emetery, crematory or oth	of		c. Location - City or					
Page Page int: If iny or	1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	JHemoval from State	AT. ZION C	FMFTFRY	4/30/99	Lange	downe, 4D				
Baltimore, permit, Pages 1 at Department of He Important: If item eny injury or other pages.	21. Signature of Funeral Service Lice	nsee	22. Name and	Address of Facility	Din Flux	ral Un	/				
B ggrea	1/Man	Jana	6386	NY Gilling	in St B	10 4 MOK	e. 402121				
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/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Hypertensive	e Arterioscl	erotic Card	iovascular	r Disease					
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requires requires should be sted by					24a. Was an a performe	d?	available prior to completion of cause				
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Vital Rysten: The Is certificate had director, page					1 ☐ Yes	2 No	1 ☐ Yes 2 XNo				
of Vitai Physicien: The Certificate ral director, pa.: To Be Co	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital:	500 · · · · • • • • • • • • • • • • • • •	Other	ath (Check only one)	a 🗆 0	~.				
	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DOA 28b. Time of 28c	. Injury at Work?	1ome 5XX Residence 28d. Describe how		ecny)				
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Division of attending P as after death. at Director: After ied in by the funerication:	4 ☐ Homicide building, etc. (Specify) City or Town, State)										
Division of the Hospital or Attanding Physiph 24 hours after death. Within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occurred at tion and/or investigation, in	the time, date and place my opinion, death occur	e, and due to the causurred at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)				
To the within To the comp	29b. Signature and title of certifier		29c. l	License number	290	l. Date signed (Mon	th, Day, Year)				
	1 Hute	me M. D	٥.	O.C.M.E.	A	PRIL 22,	1999				
3	30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Print)								
	JOSEPH PESTANER	M.D. 1	11 Penn Stre	et Baltim	ore Maryl	and 2120	1				

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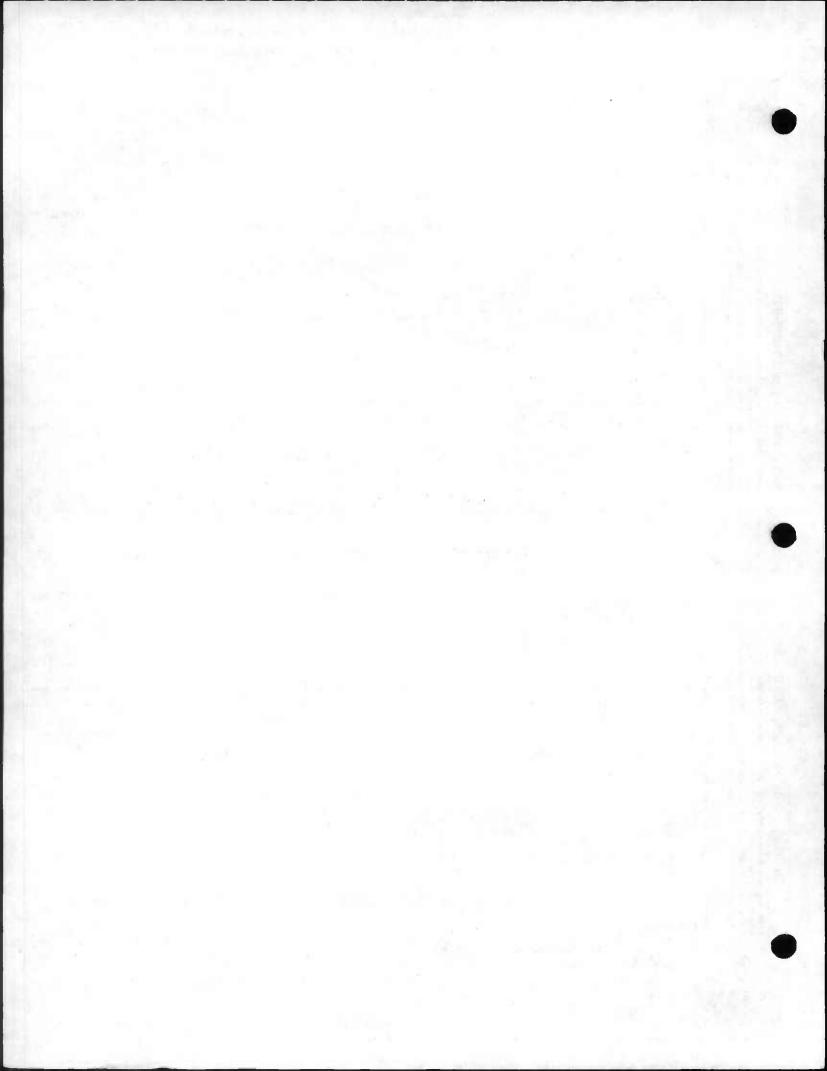
Registrar

31. Date filed (Month, Day, Year)

APR 3 0 1999

Sparke

32 Registrar's Signature



ate of Maryland / Department of Health and Mental Hygiene	99 14084
Certificate of Death Reg. No.	33 1400

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	h the Maryland	r 28a-f show inothfied at	rector

1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Day Month Year Edith B. Markey April 28, 1999 4:00 pm 4a Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Mariner Health Of Glen Burnie Glen Burnie Anne-Arundel If Undar 1 Yaer | If Under 24 Hrs. Birthplaca (Steta or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days Months Hours 1□M 200 F 214-30-2541 89 Yrs. Sept. 24,1909 MD Usual Rasidence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A 1 Yas 2 □ No Baltimore City 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code flied within 72 hours effer deeth with Hygiene. Start in a start in the start in th 1457 Hull Street 21230 United States Funeral 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Meritel Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas X No If Yes, Giva Baitimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify. White þ 3€Widowed 4 Divorced Year or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be flied will Department of Health and Mental Hygient Important: if item 27 is marked other that any injury or other traumatic avant, the page. Own Home 8 0 Homemaker 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Be James Gibson Grace (Unknown) 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 1457 Hull Street, Baltimore Maryland 21230 Robert J. Markey / Son 20b. Place of Disposition (Nama of Data 20c. Location - City or Town, State 20a. Mathod of Disposition cematary, cremetory or other place) XX Burial 2 Cramation 3 Ramoval from Stata Glen Haven Cemetery April 30, 1999 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licensee Victor P. Doda, Jr. 22. Nama and Addrass of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 Approximata Interval Between Onset end Death 23a. Part1. Entar fha diseese, or complications that caused the shock, or haart failura. List only one cause on each line. Do not entar tha moda of dying, such as cardiac or respiratory arrast, **Physician** Coronary Artery Disease /Medical Immediata Cause (Final 6 years disaasa or condition rasulting in deeth) Examiner Due to (or as a consequance of): Examiner Essential Hypertension 15 years physicien and s the burial-transit Sequentially list conditions, if eny, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Peripheral Vascular Disease Box 68760. 12 years edical Dua to (or es a consequance of) Senile Dementia 7 years ettending Physician/M Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. the been signed by ahould be detac 1 Yes 2 No 3 Probably 4 Unknown by The law requires 24b. Ware autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? Completed has pege 2 1 Yas No 1 ☐ Yes 2 €No certificate Division of Vital 8 25. Was casa rafarred to medical axaminar? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 70 1 ☐ Yas → No this 28a. Deta of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? or Attanding 5 Pending invastigation Netural 2 Accident To the Hospital or Attanding within 24 hours effer death.
To the Funeral Director: Affe compistely filled in by the fun 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Steta) 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner es stated.

[2] Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Cartifia (Check only one) 29d. Dafa signed (Month, Day, Year) 29c. License number 29b. Signatura and fitla of certifiar D14160 04/29/99 M.D.

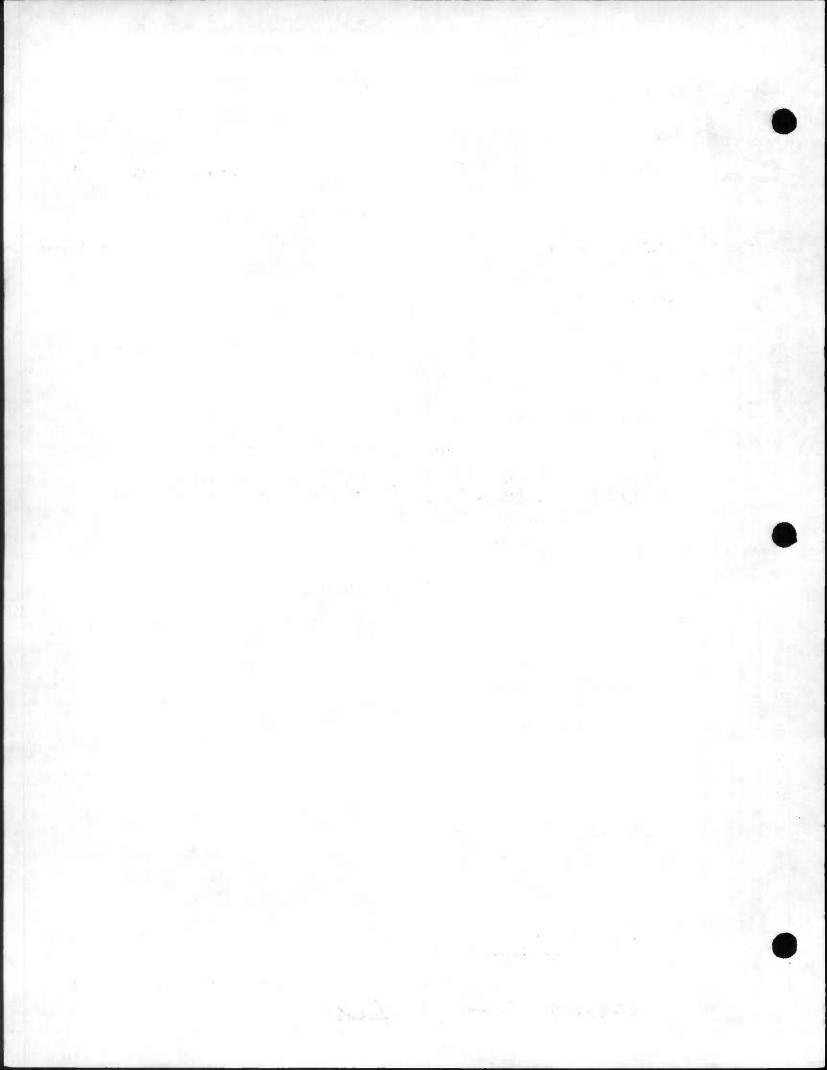
State Registrar

31. Dafa filed (Month, Day, Year) APR 2 9 1999

Harjit Singh,

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print)

5410-A Ritchie Highway Baltimore, Md. 21225 M.D. 32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Albert Roy Markel Jr. 26, 1999 April 0810 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore If Undar 1 Year If Under 24 Hrs. 5. Social Security Number Birthpleca (Stete or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1 ☑ M 2 □ F Months Days Hours 79 Yrs. 219-03-6347 Director 09/24/1919 Maryland Usual Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore 1 ☐ Yes 2€No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Belinda Avenue 21206 U.S.A. Funeral 12. Was Decadant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 ☐ Never Marriad 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Cotlege (1-4or 5+) Elementary/Secondery (0-12) Sheet Metal Machinist Manufacturing 18. Mother's Name (First, Middla, Maiden Sumeme) 17. Fathar's Name (First, Middle, Last) Be Albert R. Markel Sr. Mildred Eirman 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Evelyn Markel 15 Belinda Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4/29/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Parkwood Cemetery 22. Name and Address of Facility John C. Miller Inc. 21. Signature of Juneral Service Licanses 6415 Belair Road Baltimore, Maryland 21206 23a. Part 1. Enter the disease, or composations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Aspiration Pneumonia 2 days Examiner Due to (or as a consequence of) Examiner Stroke 23 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequance of): Physiclan/Medical Dua to (or as a consaquance of): Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Atrial Fibrillation g 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed Coronary Artery Disease 2) No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b Time of 28c. Injury at Work? Certification: 5 Panding investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 4 | Homicide 29a. Certifier 🗺 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical 2 Medical Examtner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Apr 26,1999 MD RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD Sinai Hospital of Baltimore, Hwei Lin, MD 2401 W. Belvedere Avenue 31. Date filed (Month, Dey, Year) 32. Registrar's Signatura Registrar APR 2 9 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Veer Month C. NEWMAN 23, 1999 HEHRY APRIL 12:14 PM 4b. City. Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth BALTIMORE CENTER MEDICA VETEKAN'S APPAIRS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Months Deys Hours Min. May 5, 1909 Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 15 M 2□ F Yrs. 90 245-60-7844 North Carolina Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Severn 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 1425 Washington Avenue 21144 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11. Marital Status 1 Ves 2 No5/1931 If Yes, Give 9/1961 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 0 Army Military 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Henry Sheldon Newman Nanuna Ann Allen 19e. tnforment's Name/Retetionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ivan Newman/son 1235 E. 97th Place, Thornton, Colorado 80229 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 Donetlon 5 ☐ Other (Specify) 21. Signature of Furniral Service Licensee 22. Name and Address of Facility Director Ronald S State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 It is the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, ock, or heart feiture. List only one cause on each line. Intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in deeth) ASPIRATION HOURS Due to (or es e consequence of): ALZHEIMER'S DISEASE DECADES Due to (or as e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

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Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at

nit. Peges 1 and 2 should be filed within 72 hours efter death valent and Mental Hygiene.

reportant: if item 27 is merked other than "natural", or items 23.

altimore, Maryland 21215-0020

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Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lest

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes cese referred to medicel examiner? Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28b. Time of

27. Menner of Death 1 X Neturel 2 ☐ Accident 5 | Pending Investigation 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

26. Place of Deeth (Check only one)

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

(Check only one) 29b. Signature end title of certified

29a. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Dey, Yeer)

Marc Pis

APRIL 23, 1999

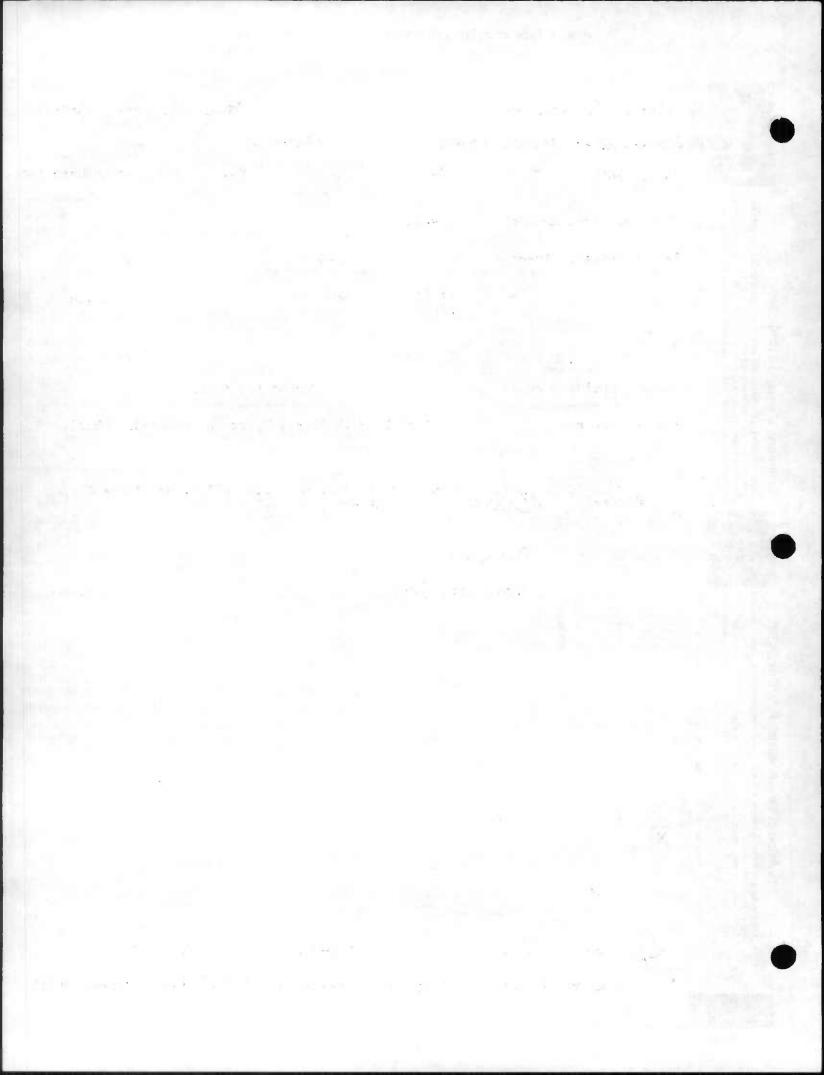
30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

MARC Fiss RUBENFELD 9738 COLLINGY MEMBOUN LANG APT. * 1B CAUREL, MARYLAND 20723 AUTHOL 31. Date filed (Month, Day, Year) APR 3 0 1999 32. Registrer's Signature

12477

State Registrar

Sports



State Registrar and address of person who complet

ith, Day, Year)

0

HARADOWS

boats

111 Penn Street, Baltimore, Maryland 21201

ed cause of death (Item 23a) (Type, Print)

32. Registrate Signature

ay.

- 111 511

YA

Reg. No

-		1. Decedent's Nam	e (First, Middle, La	ast)						2. Dete of D		V	3. Time of Deeth
Physic /Medi		2	Ma	e Rul	oin					Apri	Day 1	Year 999	1:50am
Exami		4a. Facility Name (I	If not institution, giv	e street and nu	um <i>ber)</i>				4b. City, Town, or		th 4c. Count		1.JUani
		Harmor	ny Hall						Colum	bia		н	oward
Funeral		5. Social Security N			7. Age (In yr		Month	der 1 Ye	ear If Undar 24 Hrs	8. Date of B	irth Dey, Yeer)		laca (Stata or Foreign try)
Director		194-18-	30.7	1□ M 2/√2 F	80	Yr.	S.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Jersey
and and		Usual Residence of 10a. State	10b. County		10c. C	City, Town o	or Location					1	Od. Inside City Limits
Marylan f show	0	MD	Howar	d			umbia					·	1 ☐ Yas 212 No
the 1	Director	10e. Street and Nur		d		001		z Zip Cod	Α		10g. Citizen of	What Cour	**
23a or	al Di	6336 Ce		e, Apt	t. 113						USA		
in 72 hours efter death with the Maryland "netural", or items 23s or 28e-f show esical Experient must be notified at	by Funeral	11. Marital Status 1 □ Never Marri 3 □ Widowed	ied 2 Married	Armad F	2 ⊈No ive	U,S.	 13. Was Decedent of Hispanic Origin? (Specify Yas or if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify: 			Specify Yas or Noto Rican, etc.)	r No-) 14. Raca - Amarican India Black, White, etc. Specify: White		etc.
72 ho	ted	/Sner	15. Decedent's E		1	16a. D	ecedent's U	sual Oc	cupation	rkina	16b. Kind of B	Business/Ind	dustry
Elementery/Secondary (0-12)		College (1-4or 5+) College (1-4or 5+) Owner/Op				work done during most of working Tuse retired)			Res	taura	ant		
77 - 1		17. Father's Name	(First, Middle, Last)		0 11	11007	P		me (First, Middi	le, Maidan Surnai		
id be entai ked o	To Be	To	hm Cold	atain								,	
	Ĕ	19a. Informant's Na	hn Gold			19b. M	failing Addre	ess (Str	eet and Number or Ru	Anna u <i>ral Route N</i> um	Kesofs	K. Y. . Stete. Zip	Code)
alth al			M. Rub		n				. Pearce				21111
- F E E		20a. Method of Disp	position		20b.	Place of D	sposition (A	Vam <i>e</i> of		Date	20c. Location		
permit. Pages Depertment of Emportant: If ite any injury or of once.			Cremation 3 5 Other (Special		State Me		crematory of Cremat		, Inc. 4/3	0/99	Balt	imore	e, MD
Depertment Important: I any injury o		21. Signature of Fu	neral Service Lice	2000	200.1	0	22 Name	and Ad	dress of Facility Ci	etv of	Marv1	and.	Inc.
IOE # 8		Dawh	Me Men	onald	gunar	d	299	Fr	ederick	Rd. Ba	ltimor	e, MI	21228
160	Г	23a. Part1. Enter the	he disease, or com	plications that	caused the de	ath. Do not			dying, such as cardia				Approximate Interval Between
Physician		1											Onset and Deeth
/Medical xaminer		Immediate Cause (disease or conditio		Mi	ETASTA	TIC	ADE	NO	CARCINO	MA			I WEEK
Adminici	Je.	resulting in death)		a	Due to	(or es e cor	nsequence o	of):		-			
nd	Examiner	Sequentially list co	nditions	b	Due to	(or as a cor	nsequenca o	of):					
e attending physician and of for use as the buriel-trensit		Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or	nmediate orlying			(** ***		.,.				}	
hysic the b	dica	that initiated events resulting in death) I		C	Due to	or as a con	sequence o	f):					
attending physician and for use as the buriel-trensit	cian/Medical		l	d									
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gned l	by P										105 2010	3 - 110	Sabiy 4 Colikilow
hes been signed by the je 2 should be detached	Completed b									24a. Wa per	is an autopsy formed?	ava	ere eutopsy findings allable prior to mpletion of cause death?
	Con									1	Yes 2 No	10	Yes 2□ No
is certificate director, pag	Be (25. Was case reference examiner?	red to medical						26. Place of De	ath (Check only	one)		
0 0	P	1□ Yes 2	No	Hospital: 1 🗆	Inpatient 2[☐ ER/Outpa	atient 3	DOA	Other: 4 Nursing H	lome 51 Res	sidenca 6 □Ot	her (Specify	()
After th funeral	27. Manner of Death 1 Netural 2 ☐ Accident	5 ☐ Pending investigation		of Injury oth, Dey Year)	28b. Tim Inju			njury et Nork? □ Yes 2 □ No	28d. Describe	how injury occu	rred		
in Dir	Certification:	3 ☐ Suicida 4 ☐ Homicide	6 Could not b determined	28e. Placi	a of Injury - At ling, etc. (Spec	home, farm	, street, fact	ory, offi	ca		(Street and Num own, Stata)	ber or Rura	l Route Number,
Hospital 24 hours Funeral etely filled	edical C	29a. Certifier (Check only one)	Certifying Ph	niner: On the b	asis of examir	owledge, d	eath occurre	ed at the	e time, date and place by opinion, death occu	e, and due to the urred at the time	e cause(s) and m e, date and placa,	anner as si end due to	ated. the ceuse(s)
To the within 2 To the comple	Mec	29b. Signature and	title of contiller		ner stated.		3	29c. Lica	ansa number		29d. Date signe	ed (Month	Dav. Year)
- ≯ ⊬ 8) (10hm	no			-	J	38296		ADDU	79	1999

eet and Number or Rural Route Number, Stata) se(s) and manner as stated. e and placa, end due to the ceuse(s) 29d. Date signed (Month, Day, Year) APRIL 29, 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

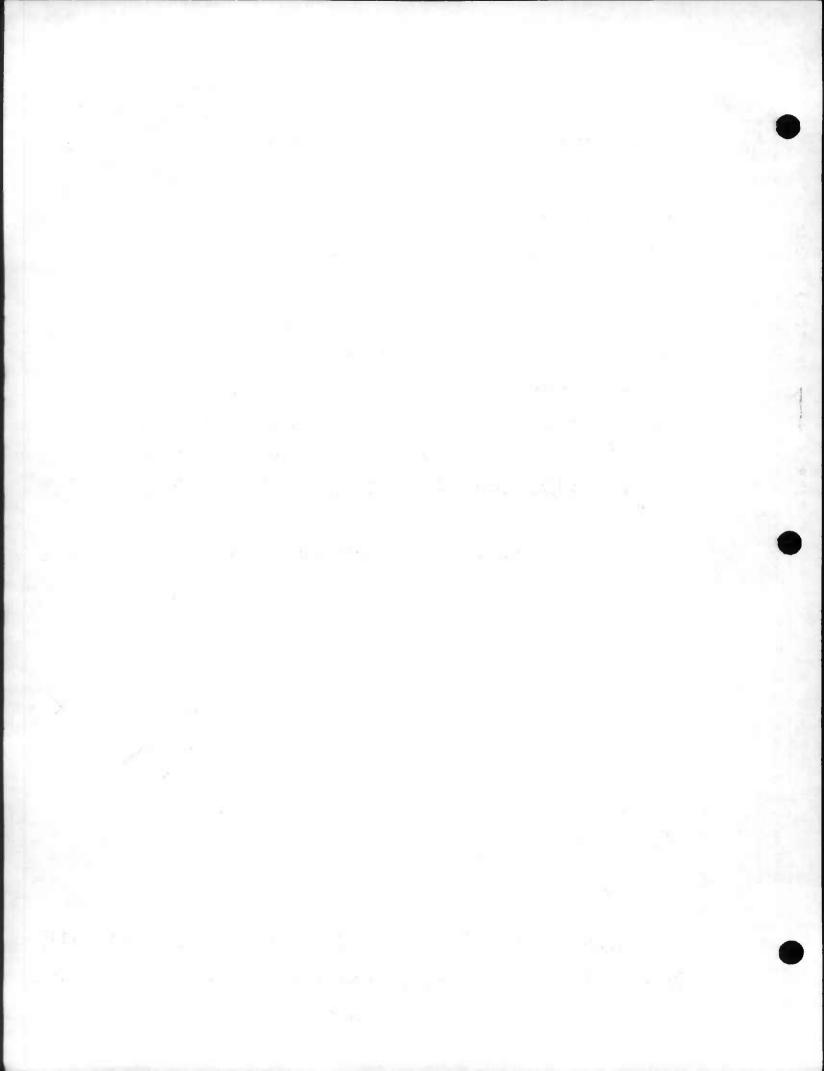
TOSEPH F. GIBBONS MD 9501 OLD ANNAPOLIS RD, ELLICOTT (ITY, MD 21042

State Registrar

APR 3 0 1999

31. Date filed (Month, Day, Year)





PI

Pleas	e Type or I State of		d / Dep		nt of F	lealth and			ne g	ble.	4089	9
Decedent's Name (First, Middle, I		leen	Grad	ce	Robi	nson	Mont	2. Dete of Death Month Day April 29, 1999			3. Time of De 8:30	
la Facility Name (If not institution, g 8620 Ke1so Driv		nber)				4b. City, Town,		Death	4c. County			
5. Social Security Number 6. 236–14–9389	Sex 1□ M 25xF	7. Age (In yrs. 80	last birthda Yrs.	y) If Under Months	1 Year Days	If Under 24 H	rs. 8. Date in. (Mont	of Birth h, Day, Yes	ar)	9. Birthp	e place (State or F ntry) nnsylva:	
Usual Residence of Decedent Oa. State 10b. County		10c. Cit	y, Town or	Location						1	0d. Inside City	
Maryland F Oe. Street and Number 8620 Kelso Dri	Baltimore			10f. Zip	Code	Middl 21221	e Rive	10g.	Citizen of '		ntry?	
1. Marital Status 1. Never Married 2. Married 3. Widowed 4. Divorced	12. Was Dece Armed For	ces? 2.[2\$No e	S. 13	3. Wes Dece If Yes, spe 1 Yes	city Cub	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes erto Rican, et	or No-	14. Rac	ce - Americ ck, White,	an Indian,	e
15. Decedent's (Specify only highest g Elementary/Secondary (0-12)		4or 5+)	(Giv life.	edent's Usu re kind of wo DO NOT u	rk done se retire	eation during most of a d)	vorking	16b.	Kind of B	usiness/In Home	dustry	
7. Father's Name (First, Middle, La			1100	136WII		18. Mother's N	lame (First, M	liddle, Maid			· · · ·	
Thomas Spacht							orence		Not		n)	
9a. Informant's Name/Relationship	(Type, Print)		19b. Ma	iling Address	s (Street	and Number or					· .	
Mr. Thomas Robi	inson /	Son				Road					21234	
0a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Special		State	emetery, cr	position (Ner remetory or o	ther ple	Gdns.	Date 5/3/19		Location el Ai			
21. Signature of Funeral Service Un	money /	24	/	Duda-	Ruck	ss of Facility Funeral					nc. 1222	
23a. Part1. Enter the disease, or co shock, or heart failure. List on immediate Cause (Final disease or condition	mplications that ca ly one cause on ea	ich jihe.				ng, such es card					Approximate Intervel Betwee Onset and Dec	
esulting in death)	a	Due to (o	ras a cons	equence of):		OUS STI						
Sequentially list conditions, amy, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last	с	PER	NICI	equence of):		em 14	-			-		
	d	Hu	47A	LITE	RN	IA.				İ		
art II. Other significant conditions					ause giv	en in Part I.	23b	Did tobac	/		the cause of e	
							24a.	Wes en au performed		av	ere autopsy find ailable prior to mpletion of cau death?	
								1 🗆 Yes	2 DH6	1[Yes 2□ No	,
5. Was case referred to medical examiner?						26. Place of [Death (Check	only one)				
	Hospital:	patient 2	ER/Outpati		Oth	er: 4 Nursing		Residence	6 □Oth			

Physician /Medical Examiner

Physician /Medical

Examiner

Director

Funeral

Be Completed by

To

Funeral Director

permit. Papes 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an Magain.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burlet-transit

Division of Vital Records, P.O. Box 68760.

Part II. Other eignificant conditions of DEG - J		23b. Did tobacco use co 1 ☐ Yes 2 ☑ No	ntribute to the cause of death? 3 Probably 4 Unknown		
				24a. Wes en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
				1 ☐ Yes 2 ☐ Mo	1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
1 Yes 2 LNo	Hospital: 1 ☐ Inpatient 2 ☐	OA Other: 4 Nursing	Home 5 PAesidence 6 □Oth	ner (Specify)	
27. Manner of Death 1 QNatural 5 Pending 2 Accident investigation	7. Manner of Death 1. Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury			28d. Describe how injury occur	red
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, facto	ry, office	281. Location (Street and Numb City or Town, State)	ber or Rurel Route Number,
29a. Certifier (Check only one)	raician: To the best of my kno iner: On the basis of examine and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and place, in my opinion, death occ	ce, end due to the ceuse(s) and me curred at the time, date and place,	anner as stated. and due to the cause(s)
29b. Signature and title of certifier		29	c. License number	29d. Date signe	d (Month, Dey, Year)
> Saba Si	deligs.	mo .	D41496	4/29	9/99

MD 21221

State Registrar

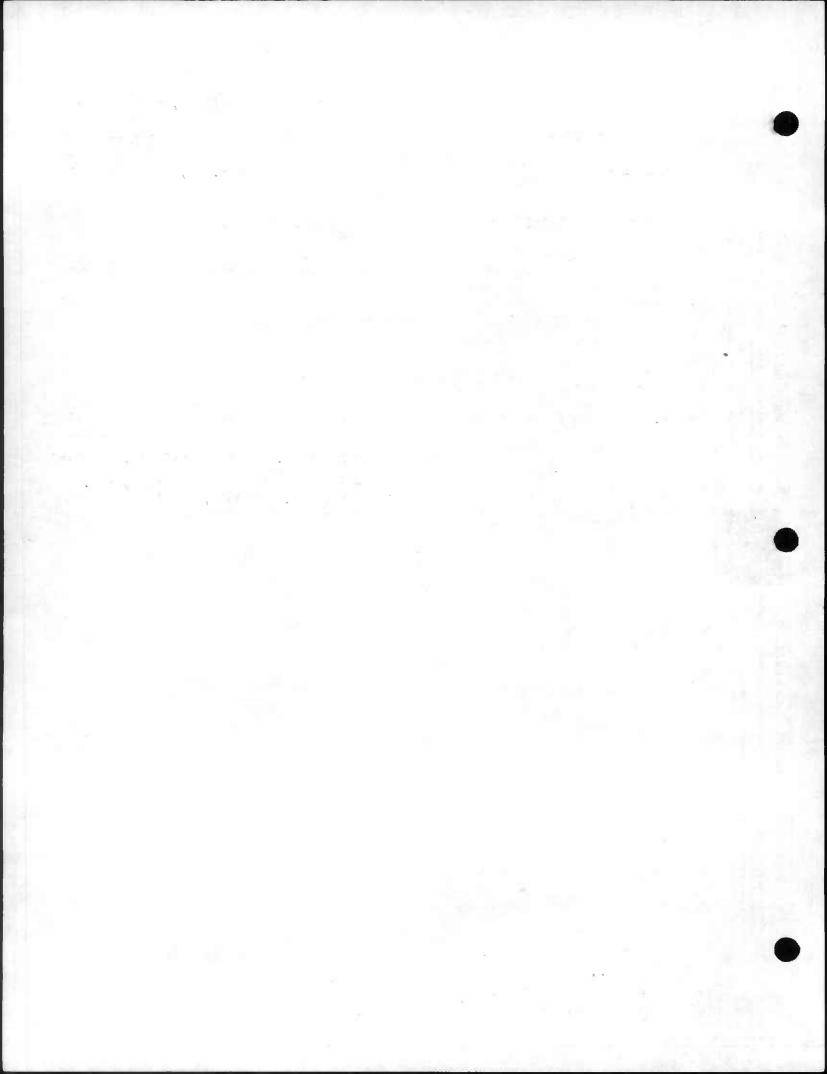
31. Date filed (Month, Day, Year) APR 3 0 1999

SABASIDOIDI, 405 22. Registrar's Signature

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Sports

STEMMERS RUN



Please Type or

7. Age (In yrs. last birthday)

93

Yrs.

10c. City, Town or Location

10f. Zip Code

Type or Print in Black Indelible Ink. Assure	All Copies	Are L	egible.	
State of Maryland / Department of Health and	Mental Hy	giene	9.9	14090
Certificate of Death		Reg. No.		
st)	2. Dete of De Month	eth Dey	Yaar	3. Time of Deeth
RITTER	APRIL	25	1999	10:50pm

4b. City, Town, or Location of Deeth

Rossville

Essex

21221

Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.)

| If Under 1 Yaer | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Sept • 22 1905

4c. County of Deeth

10g. Citizen of Whet Country?

14. Raca - American Indien, Black, White, etc.

Martin MArietta

White

USA

Specify:

Baltimore

Birthplace (Steta or Foreign Country)

PA

10d. Insida City Limits

Maryland

Approximete Intervel Between Onset end Death

24b. Were eutopsy findings available prior to completion of cause of deeth?

1 ☐ Yes 2 ☐ No

1 ☐ Yes ▼ ☐ No

Physician /Medical Examiner 1. Decedent's Name /First, Middle Last

PAUL

5. Sociel Security Number

177-10-0977

10e. Street end Number

11. Marital Status

10a State

Director

Funeral

Md.

Usual Residence of Decedent

E

Manor Care - Rossville

6 Sax

Baltimore

1DTM 2DF

12. Wes Decedent Ever in U,S. Armed Forces?

4e. Fecility Name (If not Institution, give street end number)

10h County

8 Wilbur Road

1 Never Married 2 Married

Funeral Director

with the Merylend tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mod cal Examiner must be notified at death v e filed within 72 hours efter all Hygiene. permit. Pages 1 and 2 should be file Department of Health and Mentel Hy, Important: If item 27 is marked other any injury or other traumatic event.

Baltimore, Maryland 21215-0020

Physiclan /Medical Examiner

ettending physician end for use es the buriel-trensit Box 68760. certificate be Records, P.O. should be deteched signed by peen hes Division of Vital director, this funerel al or Attanding F s efter death. I Director: After After

XX Yas 2 ☐ No If Yes, Give Year or Detes: 1 ☐ Yes 2 TNo Specify: by 3 A Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Tool & Die Shop 8th 17. Fethar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Sumama) Be unknown unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) Mark Gonce / friend 3 Birsay Court Baltimore Md. 21236 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Ramoval from Stete Metro Crematory Inc. 4/27/99 Baltimore 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Servica Licanse 22. Name end Address of Fecility Connelly Funeral Home of Essex omplications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, ity one cause on each line. 300 Mace Ave. Baltimore Md. 21221 23a. Part1. Sema Immediate Ceuse (Finel diseese or condition resulting in death) Examiner nurado Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Physician/Medical 23b. Did tobacco use contribute to the cause of death? Part II. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Pert f. Yes 2 No 3 Probably 4 Unknown þ Completed 24a. Wes en eutopsy 1 Yes 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Naturel 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Certifying Phyeicfen: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner stated. 29a. Certifier Medical (Check only 29b. Signeture and title of certifiar 29c. License number 29d. Dete signad (Month, Dey, Yeer) 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

1006 Taylor Hvenue

State Registrar

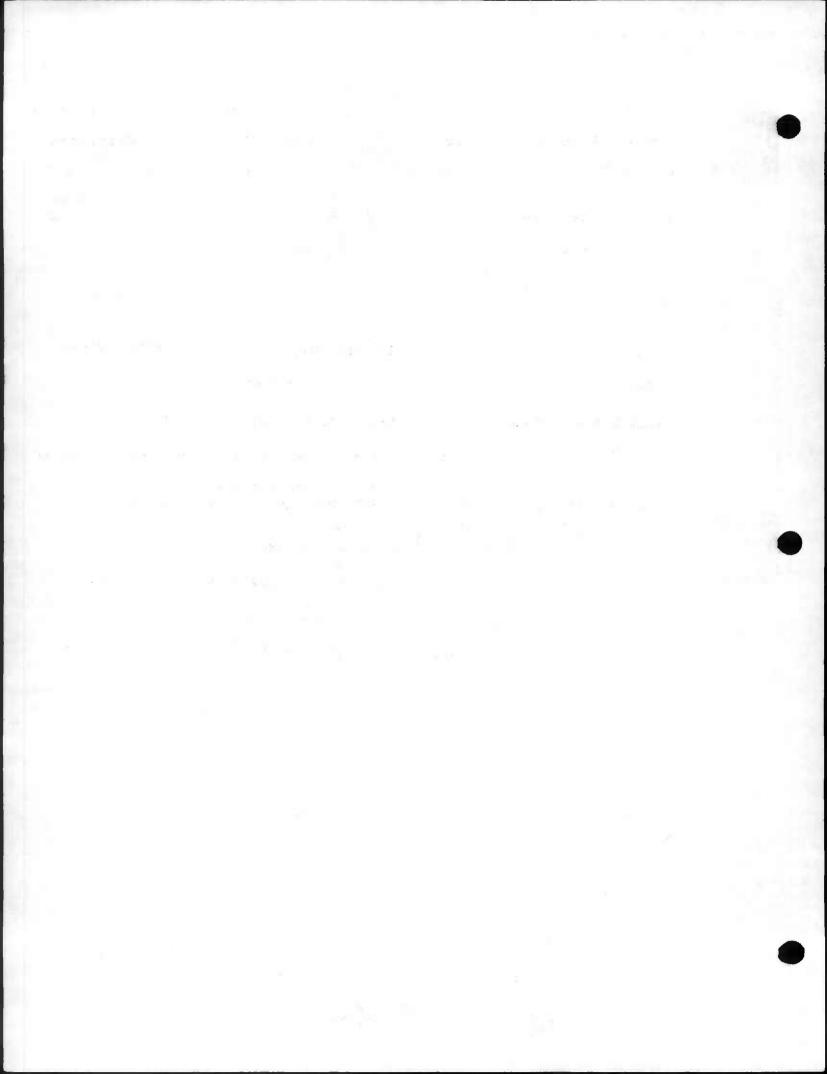
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filled in by

To the Hospital within 24 hours e To the Funeral C

31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Physician-WILLIE RAY ROBERTSON ROBERSON 6:10 AV 2 /Medical 4e Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4103 RIDGEWOOD AVE BALTIMORE If Under 1 Year If Undar 24 Hrs. 8. Data of Birth (Months Days Hours Min. 1994) 1994 (Months Dey Yeer) 5. Social Security Number Birthplaca (State or Foreign Country)
 N C 7. Age (In yrs. last birthday) 239-14-8307 ₩ 2 F 95 Months N.C. Yrs. Usual Rasidence of Decedant 10c. City, Town or Location 10e State 10b. County 10d. Inside City Limits 1 Yes 2 No MD. N/A BALTIMORE Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4103 RIDGEWOOD AVE. 21215 USA Funeral 12. Wes Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, Whita, atc. 1 Yas 2 No It Yas, Giva Yaar or Datas: 1 ☐ Naver Marriad 2 ☐ Married 1 Yas 2 No Specify: Specify: BLACK by 3√ Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collage (1-4or 5+) COOK FOOD 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) SAMUEL ROBERSON ELLA FRANKLIN 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) WILLIE RAY ROBERTSON(SON) 4103 RIDGEWOOD AVE. BALTIMORE, MD 21215 20b. Place of Disposition (Neme of cemetery, cremetory or other p 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) METRO CREMATORY 4-30-99 BALTIMORE, MD. 22. Name and Addrass of Facility VERNON R. BAILEY FUNERAL SERVICE 21. Signature of Funeral Sarvice Licansae 1721-27 N. MONROE ST. BALTIMORE, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximata Intarval Between Onsat and Death Immadiata Causa (Final disaasa or condition rasulting in daath) myocardial inforction Immediate (Dua to (or as a consequence ot): artery disease Examine NEIN 00 Sequantially list conditions, if any, laading to immadiata ceuse. Enter Underlying Cause (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence ot): Physician/Medical Dua to (or as a consequanca ot): Part II. Other algnificant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Althei dementia þ 24b. Wara autopsy tindings available prior to completion of ceuse of death? 24a. Was an autopsy performad? Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cesa ratarred to medical axaminar? Be 26. Placa of Daath (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 10 1 Yas 2 No 27. Mannar of Death 28a. Data of Injury (Month, Dey Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? Certification: 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be datarmined 3 Sulcida 28f. Location (Straet end Number or Rurel Route Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, straat, tactory, office building, atc. (Specify) 4 ☐ Homicida 29a. Cartifiar 12 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as statad. (Check only one) 2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licensa number 29b. Signature end titla of certifier W. Krooks 043636 30. Nama and addrass of parson who completed cause of death (Itam 23a) (Type, Print) orleg Rainmore MD 21224 15 31. Data tiled (Month, Day, Year) 32. Ragistrar's Signature

Willie Kay Roberson permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Meryle Department of Health and Mentel Hygiene. Important: if itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mod all Earth or must be notified a once. Baltimore,

Physician /Medical **Examiner**

Funeral

Director

28a-f show

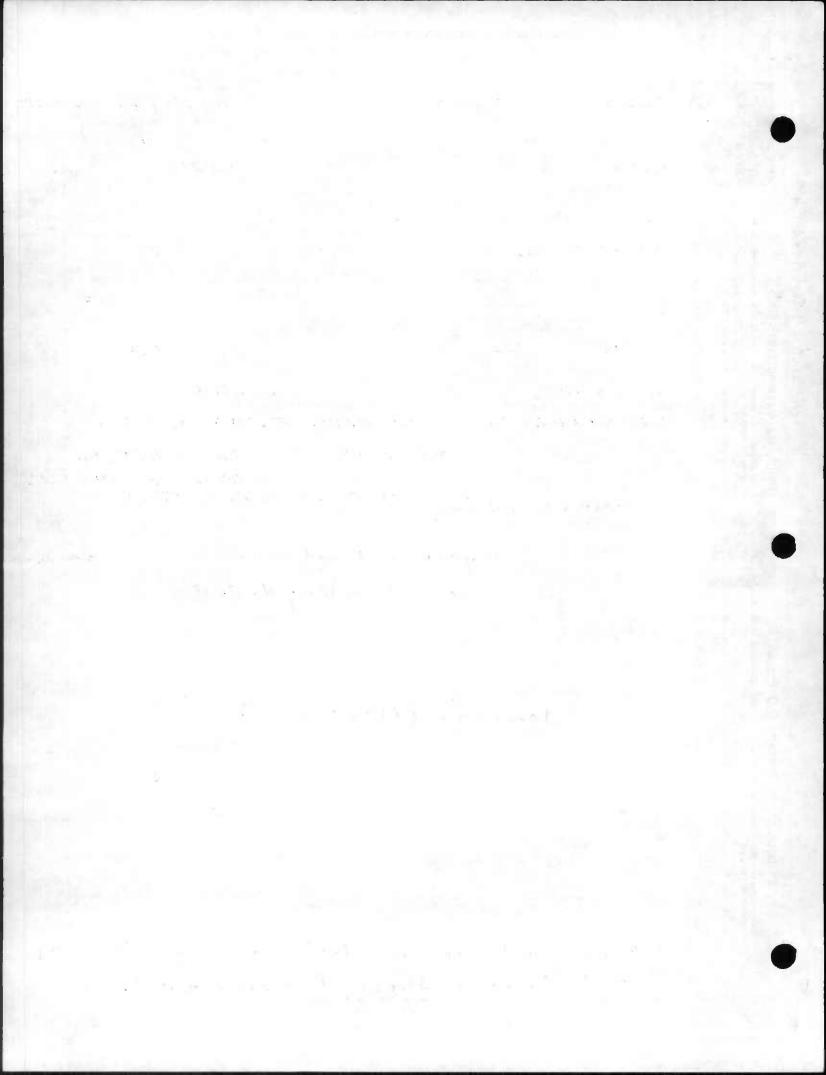
the Merylend

physician end s the buriel-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 for use es ed by the deteched been significant certificete has b lirector, page 2 st Physician: this After this or Attanding To the Hospital or Attandir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu death.

State

Registrar

APR 3 0



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 000 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last 2. Date of Death 3. Time of Death **Physician** /Medical ation of Death 4e Facility Neme (If not institution, giva street end number) 4b. City, Town, or Loc 4c. County of Death **Examiner** LOREIN NUTSING HOM 6334 Cedar Lane Rd .0 If Under 24 Hrs. 8. Date of Birth Hours Min. Month, Day, HOW 18RA If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 22 F 9 Yes Md Director 40 5059 Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow 1 Yes 2 No Director HINARG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò CARRILLON 210 4.5.A 48 items 23s 10070 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or Black 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Phygiene. Important: if Item 27 is marked other than "n any injury or other traumatic avant, in a Mad pinds. unile CT. Elementery/Secondery (0-12) College (1-4or 5+) 1000. 2415 Callege 17. Fether's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Benjamin 7-RANCIS ALVERTA 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md DONALD ELLICEH CITY CARRILLON DrIVE 10070 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremetion 3 ☐ Removel trom State artutus, ma 5/1/96 hulis mengi t 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Neme and Address of Fecility 1304 m Ur. rech Locks Locks 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. Approximate tntervel Between Onset end Death **Physician** Immediate Ceuse (Finel disaase or condition resulting in death) /Medical **Examiner** Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last The law requires that the death certificate be execu Box 68760. Physician/Medical Dua to (or as a consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes signed b Records, by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed 2 No 1 Tyes 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attanding Physician:
 A hours after death.
 Funeral Director: After this certifical etaly filled in by the funeral director; 25. Wes case reterred to medical axaminar? 86 26. Place of Death (Check only one) Hospitel: 1 ☐ tnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Sunursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 27. Mannar of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. tnjury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 | No 2 Accident 6 Could not be To the Hospital or Atta within 24 hours after de To the Funeral Directo completaly filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of tnjury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

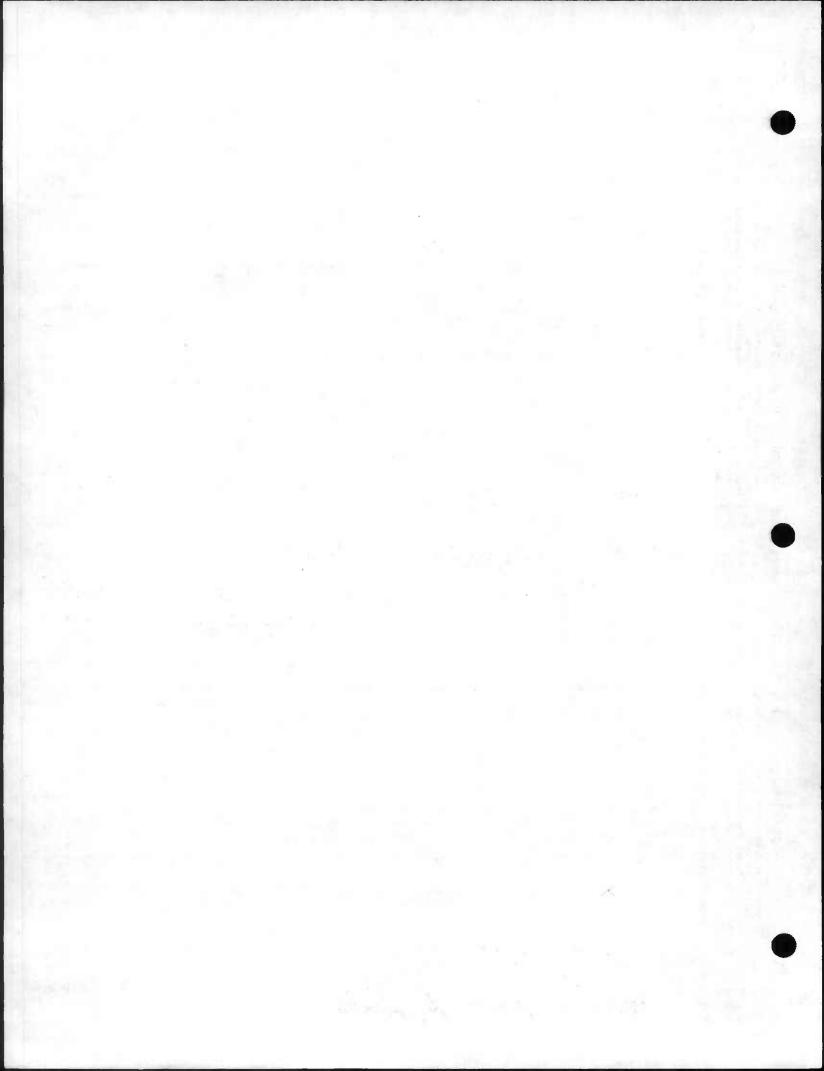
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier 29b. Signeture end title of certifie 29d. Date signed (Month, Day, Year) 29c. License number ed cause of deeth (Item 23a) (Type, Print) Aurapolis Rd 85 10

Registrar **DHMH 16 Rev 6/95**

State

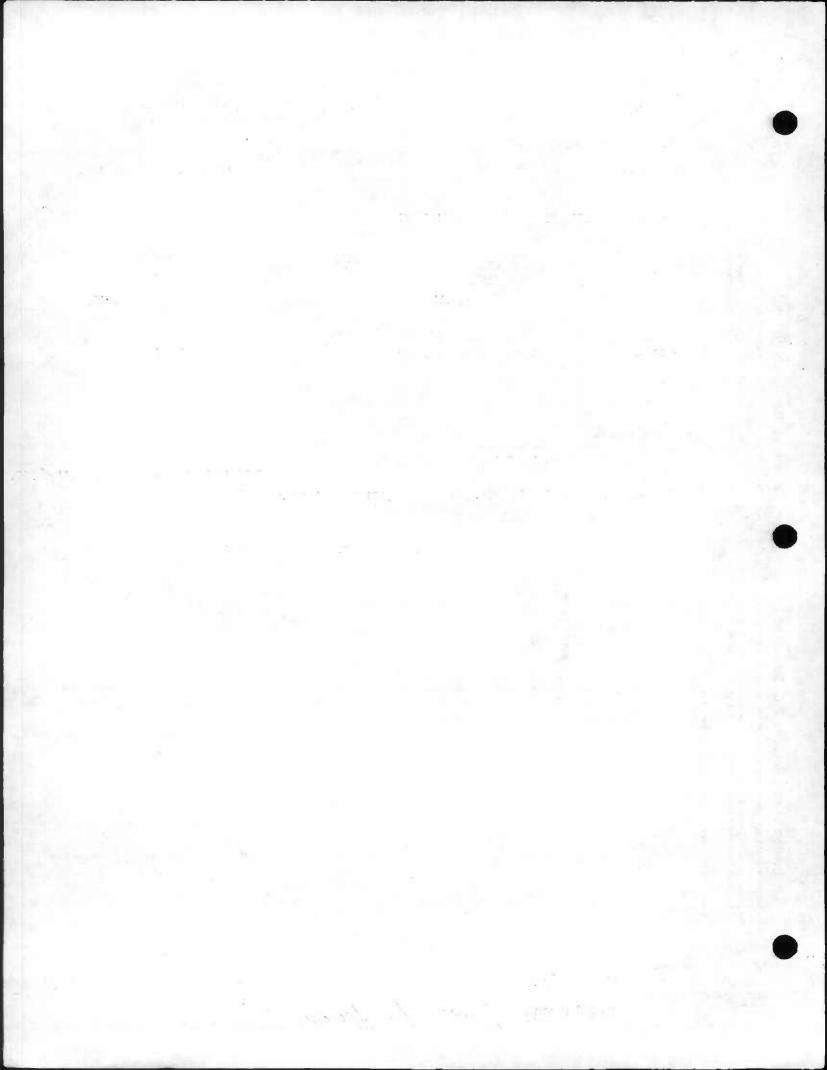
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32. Registrer's Signetur



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obert Swinfo	rd		State of M	laryland i		rtment of t	Death		giene Reg. No.		4093	
Physician	1. Decedent's Name		st)		Si	NIN F	ned	2. Dete of De Month April		Year	3. Time of Death 9:00 P.M.	
/Medical Examiner		-	e street and number	7)			4b. City, Town, or			ly of Death	19.00 F.M.	
			ryland Ho	spital			Baltim			I/A		
Funeral Director	5. Social Security N 214-12-575	5				If Under 1 Year Months Days	Hours Min.		th y, Year) 9. Birthp Coun 1921 NEW		place (State or Foreign ntry) YORK	
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or 28a-f s be notified Directo	10e. Street and Nu	mber				10f. Zip Code			10g. Citizen of	What Coun	itry?	
	14922 DOV	ER ROAD				21136			U.S.A	•		
020 us after death virt, or thems 23 Saminer meat by Funeral	11. Marital Status 1 Never Marr 3 Widowed	ied 2 Married	12. Was Deceden Armed Forces 1 [X] Yes 2 [If Yes, Give Year or Dates] No	1	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Sean, Mexican, Puer Specify: UNK NOWN	Specify Yes or No to Rican, etc.)	Speci	ice - Americ ack, White, ify:		
2 hours salure		15. Decedent's E	ducation				pation during most of wo		16b. Kind of I			.M
Maryland 21215-0020 at 2 should be lited within 72 hours at 22 should be lited within 72 hours at 7 is marked other than "natural", or traumetic event, the Medical Examp To Be Completed by F	Elementary/Seco	ide completed) College (1-4or UNKNOWN	5+)	(Give I life. D	O NOT use retire	rking	FARMING					
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yla Ment Ment Ment Ment Ment To I	UNKNOWN						UNKNOWN					
Mar 2 sh and 1s m	19a. Informant's N	ame/Relationship (Type, Print)	1	19b. Mailin	g Address (Street	t and Number or R	ural Route Numb	Number, City or Town, State, Zip Code)			
E 20 10 10	UNKNOWN 20a. Method of Dis	nocition		20h Place	UNKNOV	NN sition (Name of		Date	20c. Location	- City or To	wen State	_
Baltimore, aemit. Pages 1 a Department of Hea moortant: If Nem my Injury or othe	1 Burial 2 4 Donation	☐ Cremation 3 ☐ 5 ☐ Other (Specif	0000	etery, crem	etory or other ple	(Ce)	Date					
Ball Departiment in policy	21. Signature of Fu		IRECTOR PER	. DVR		Neme end Addre	MARYLAND 2		MY BOARD	, 655 W	. BALTIMORE :	ST
Box 68760, selb certificate be executed estending physician and for use as the buriel-transit claryMedical Examiner	Immediate Cause disease or condition resulting in death) Sequentially list coil any, leading to incause. Enter Unde Cause (Disease or that initiated eventuresulting in death)	nditions, nmediate rhying injury	B C d	Due to (or es	s a consequ	uence of):	grene and	d compli	cations	The same	D	
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= F # 0								10	Yes 2 XNo	1[Yes 2□ No	
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Ing Phy After this funeral d	1 New 2 □ 27. Manner of Deat 1 □ Natural 2 □ Accident 3 □ Suicide		28a. Date of Ing (Month, D	ient 2 ER jury ay Year) 28	b. Time of Injury Found	28c. Inju	4 LI Nursing	at home	how injury occupinned k	otw. w	pject fell vall & bed	
DIVISION THE OF AREA OF THE OF AREA OF THE O	4 ☐ Homicide	determined	289. Place of it	njury - At home etc. (Specify)		le home.		28f. Location (City or To Reister			al Route Number, Dover Road Land.	
To the Hospital or within 24 hours eft To the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only one)	1∑ Certifying Ph 2☐ Medical Exar	ysician: To the best niner: On the basis and manner s	of examination	dge, death and/or inv	occurred at the ti estigation, in my	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and n date and place	nenner es s , and due to	lated. the cause(s)	
To the common of	29b. Signature and	title of certifier	K. Ja	to M	1.	29c. Licens	se number	2	29d Date sign	ed (Month,	Day, Year)	
	30. Name and addr	ess of person who	completed rause of	death (Item 23	So (erint)	REELE	St. B	Leto,	MI) a	2/201	
State Registrar	31. Date filed (Mon	n, Day, Year) APR 3 0 1		trar's Signature	B.	Spar	6					



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Physician /Medical

Examiner

Funeral

Director

r than "natural", or frams 23a or 28a-f show the Medical Examiner must be notified at

727 is marked other than "ry traumatic event

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permit. Page Department of Important: If any injury or

Physician /Medical

Director

Funeral

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Certification: To

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29a, Certifier (Check only one)

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21215-0020

Baltimore, Maryland

State Registrar

31. Dete filed (Month, Day, Yeer)

30. Name end e

29b. Signature and the of outlifier

32. Registrar's Signature

er: On the basis of and manner stat

Osler Medical Center, 7600 Osler Drive, Suite 203, Baltimore, Maryland

Tilh (Item 23e) (Type, Print)

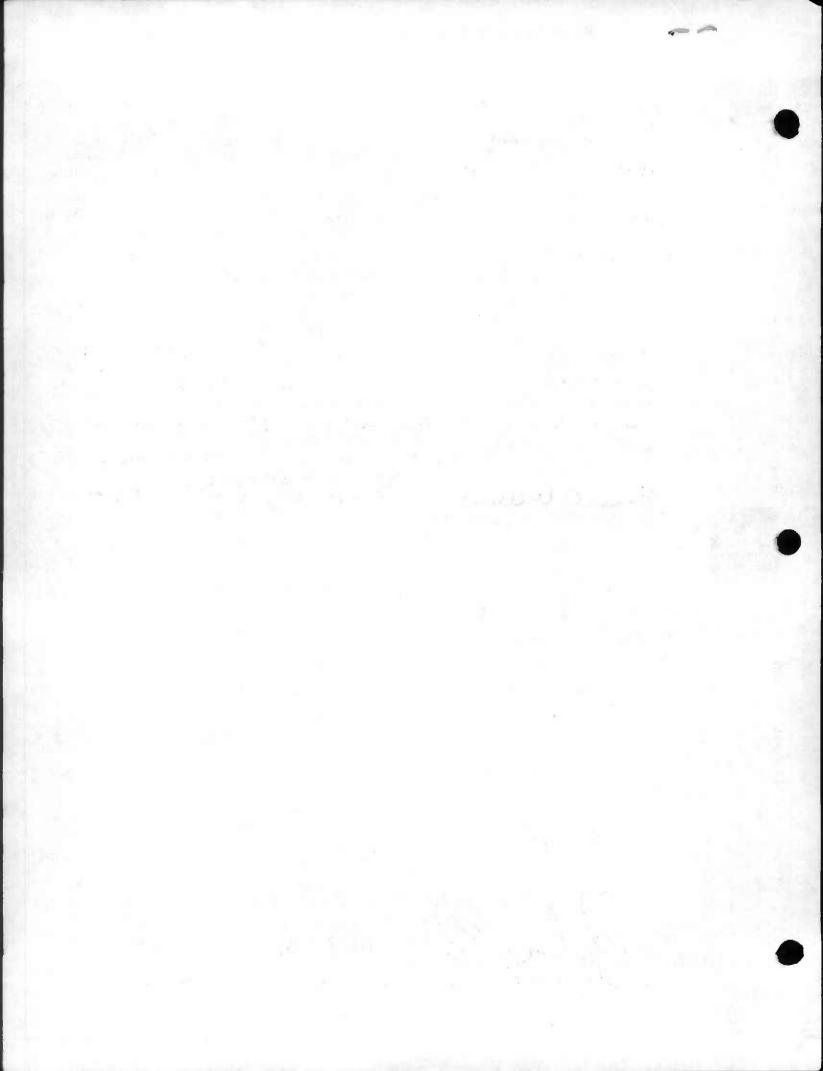
**Ee Thying Physician: To the best of my kindwadge, death occurred at the time, dete and place, end due to the cause(s) and menner as stated.

on end/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Dey, Yeer)

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** April 0400 22 Harry Lee Stoner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Deaton University of MD Medicine Baltimore N/A6. Sax If Under 1 Year If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplaca (Stata or Foreign Country) **Funeral** 1⊠M 2□ F Min Months Days Hours Director 217-62-4350 44 JAN 8, 1955 Pennsylvania Usuel Residence of Decadent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show must be notified at Director MD 1☑ Yes 2□No Baltimore 289-1 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? ò 502 Arlington Herns 23a 21223 USA Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Black, White, etc. 1 Never Married 2 ☐ Married b 1 ☐ Yes 2 ☐ No Specify: Specify: Black ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Cook Restaurant 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middla, Malden Sumeme) Be 1 and 2 should be Health and Mental Important: If them 27 is marked of any injury or other traumatic events. Joseph Dudley Arlene Stoner 19b. Mailing Address (Street end Numbar or Rural Route Number, City or Town, Stete, Zip Code) 21230 19a. Informent's Name/Relationship (Type, Print) 2402 Marbourne Ave. Apt. 2C Baltimore, Arlene Weatherbee/Mother 20b. Plece of Disposition (Neme of cemetery, cremetery or other place) 20e. Method of Disposition 20c. Location - City or Town, State to 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 4/27/99 Baltimore, MD 21. Signature of Echeral Service Licanse 22. Name end Address of Facility Cremation Society of MD, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximata

Interval Bahasas Approximeta Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Disseminated mycobacterium Avium Complex
Due to (or es e consequence of): disease or condition resulting In death) Examiner Acquired Immono deficiency Syndrome Examiner The law requires that the death certificate be executed physician and is the burial-trans Sequentially list conditions, if eny, laading to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Lest Box 68760. Physician/Medical Due to (or es e consequence of) P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown should be d Records, þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed paga 2 2 N cartificata 1 ☐ Yes 2 ☐ No Vital Attending Physician: director, 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 of this funaral 27. Menner of Deeth Date of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred Aftar Division 1 Neturel 5 Pending 1 Yes 2 No death. Director: A 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Straet end Number or Rurel Route Number, City or Town, Stete) 4 Homloide JO. pelli 24 hours Hospital 10 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Exeminer: On the best of axamination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end mannar stated. To the Hospi within 24 hou To the Funer complately fil Medical 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) alexanders D27087 30. Name and address of person who completed cause of death (Item 23e) (Type, Print).

CARLA S. ALEXANDER, MO 29 S. BREENE ST. SUITE 300 BOUT, MIL 21201 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Death Month Yaar **Physician** ROSA MARIE VAUGHAN 11-45 pm APRIL 26 1999 /Medical 4a Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAMARITAN HOSPITAL NA If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Yeer) 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1 M X X F Months Yrs. 78 10-26-20 MD Director 217-26-8547 Usual Rasidance of Decedant d 2 should be filed within 72 hours efter deeth with the Merylen thend Mentel Hygiene.
7 is marked other than "natural", or items 23s or 28s-f show traumstic svent, the Meylen Execute mail to recting the menters. 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits MD Baltimore 1X Yes 2 No Director 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of Whef Country? 301 McMechen Street Apt. #223 21217 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas ② No If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian. Black, Whifa, atc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 ☐ No Specify: Specify: Black þ 3X Widowed 4 □ Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education ify only highast grada complated) 16b. Kind of Businass/Industry (Specify only highast g Flementery/Secondary (0-12) IOth Grade College (1-4or 5+) NA various trades Domestic permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 Is marked othe eny Injury or other treumatic svent, pince. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Unknown Rebecca Greene 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) 19a. informant's Name/Ralationship (Type, Print) 2827 East Biddle Street Baltimore, MD 21213 Patterson Mary 20b. Placa of Disposition (Nama of comatary, crematory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data MBurial 2 Cramation 3 Ramoval from State Baltimore Cemetery 04-30-99 Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue Part 1. Enfar tha disease, of complications that caused tha death. Do not anter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Usy only one cause on a set line. Approximata Intarval Batween Onsat and Daath **Physician** /Medical Immediata Causa (Final disaase or condition resulting in death) S'EPSIS **Examiner** Dua to (or as a consequence of): Examiner Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disaase or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No GASTROINTESTINAL BLEEDING by 24b. Wara autopsy findings availabla prior to 24a. Was an autopsy Completed DIABETES MELLITUS completion of causa of death? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No ISCHEMIC CARDIOMYOPATHY 25. Was casa rafarrad to medical axaminer? Be 26. Placa of Death (Chack only ona) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yas 2☑ No 1 Inpatiant 2 □ ER/Outpetient 3 □ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yas 2 ☐ No invastigation 6 Could not be determined 3 ☐ Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steted.

2 Medicat Examtner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signatura and title of continuo 29c. Licansa number 29d. Data signed (Month. Dav. Year) P-12560 RESIDENT MD APRIL 1999 30. Nama and eddrass of person who complated cause of death (Itam 23a) (Type, Print) GABA, SAMARITAN HOSPITAL, BALTIMORE, MARYLAND 400 D 31. Data filad (Month, Day, Yeer) 32. Registrar's Signatura State APR 3 0 1999

DHMH 16 Rev 6/95

Registrar

physician end s the buriel-transit

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I Director: After this certificat et in by the funerel director, pa

To the Hospital or within 24 hours eff To the Funeral Di completely filled in

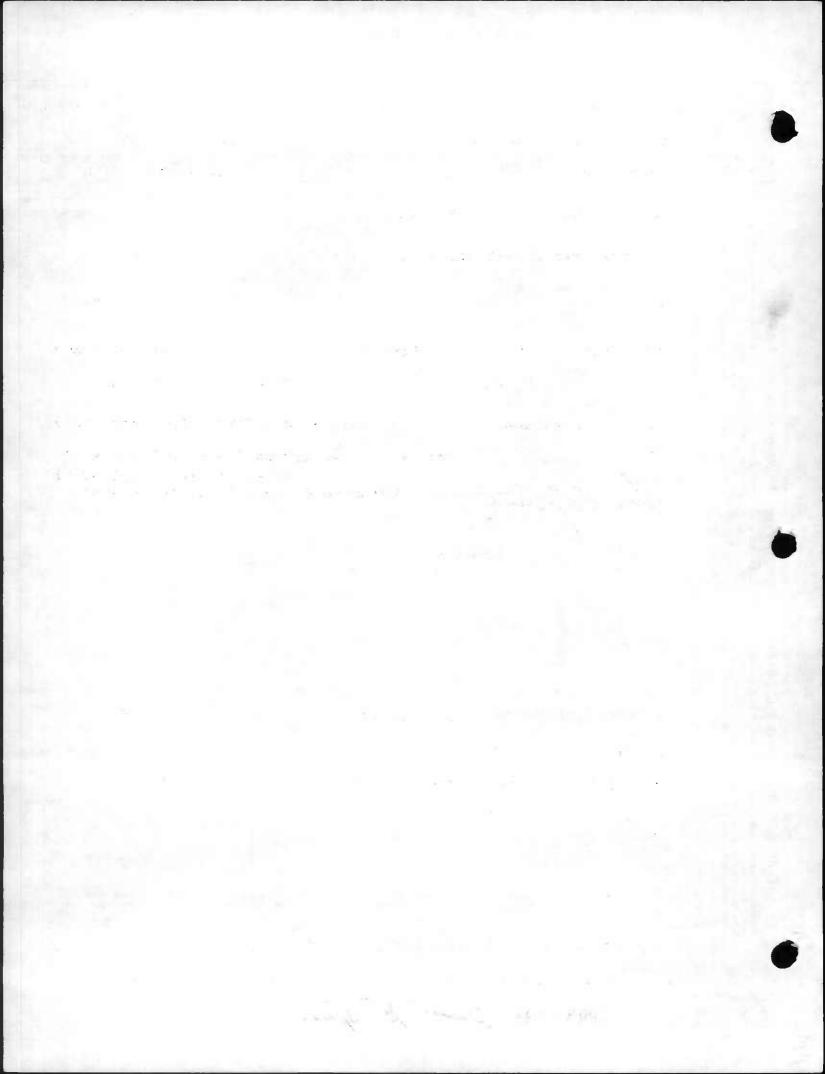
The law requires that the death certificate be executed

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Records,

Division of Vital

the Meryland



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (ITEM: #23 B PER MD G770 4-30-99 WR. Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death 130 A EORGE 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give straat and number) 4c. County of Death If Under 24 Hrs. 8. Date of B. JOHNS II Under 5. Social Security Number 6. Sax 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) 7. Age (In yrs. last birthday) 10 M 20 F Months Days Hours Min Yrs. 220-40-7871 55 Sept. 5, 1943 Maryland Usual Rasidanca of Decedant 10a State 10h County 10c. City. Town or Location 10d. Insida City Limits YYas 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 909 West 33rd Street 21211 USA 14. Race - Amarican Indian, 12. Was Decedent Evar in U,S. Armed Forcas? 1 Yas 2(T) No If Yas, Give Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yas XX No Spacify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuat Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Baltimore 12 Umpire Dept of Recreation 18. Mothar's Nama (First, Middle, Maidan Surname) 17. Fathar's Nema (First, Middle Last) Albert P. Warner Livinda Taylor 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ratationship (Type, Pnint) 909 W. 33rd Street, Baltimore, Maryland 21211 Tammy Clark 20b. Piece of Disposition (Nema of cametery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete Data 1 Buriai 2 Cramation 3 Removal from Stata ☐ Othar (Specify) 4/13/99 Woodlawn, Maryland Woodlawn Cemetery 21. Signature of 22. Nama and Addrass of Facility arai Sarvice License Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 Entar the disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, or his infailure. List only one cause on sech line. Approximata Intarvat Between Onsat end Daath Immadiata Causa (Final diseasa or condition resulting in death) 5 MINS CORONARY ARTERY DISEASE Sequantially tist conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avents resulting in daath) Last Dua to (or as a consaquanca of): Due to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 4 Unknown 3 Probably 1 Tyes 2 No 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy No No 1 Yas 1 Yes 25. Was casa rafarred to medical 26. Placa of Death (Chack only ona) axaminar? Othar: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? Natural 5 Panding invastigation 1 🗌 Yas 2 No 2 Accidant 6 Coutd not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28a. Ptaca of Injury - At homa, farm, straet, factory, office building, etc. (Specify)

Examiner physician end the bunal-transit law requires that the death certificate be exec Division of Vital Records, P.O. Box 68760 Physician/Medicai SBS usa the been signed by the should be detach by Completed pega 2 certificata has Hospital or Attending Physician: 24 hours eftar death. Funeral Director: After this centilics director, Be 2 funerei Certification:

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Exemper must be notified at

Directo

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours effect. Department of Health and Mentel Hygiane. Important: If item 27 is marked other than "natural", or har any injury or other traument.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

complataly filled in by 24 hours

> 30. Nama and admens of person who complated causa of daath (Itam 23a) (Type, Print) State Registrar

Medical

4 Homicida

29b. Signatura and titla of certifian

29a, Certifiar

31. Data filed (Month, Day, Year)

HOPKINS

1x Certifying Physician: To the best of my knowladga, daath occurred at tha time, data and place, and due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and mannar statad.

29c. Licansa number

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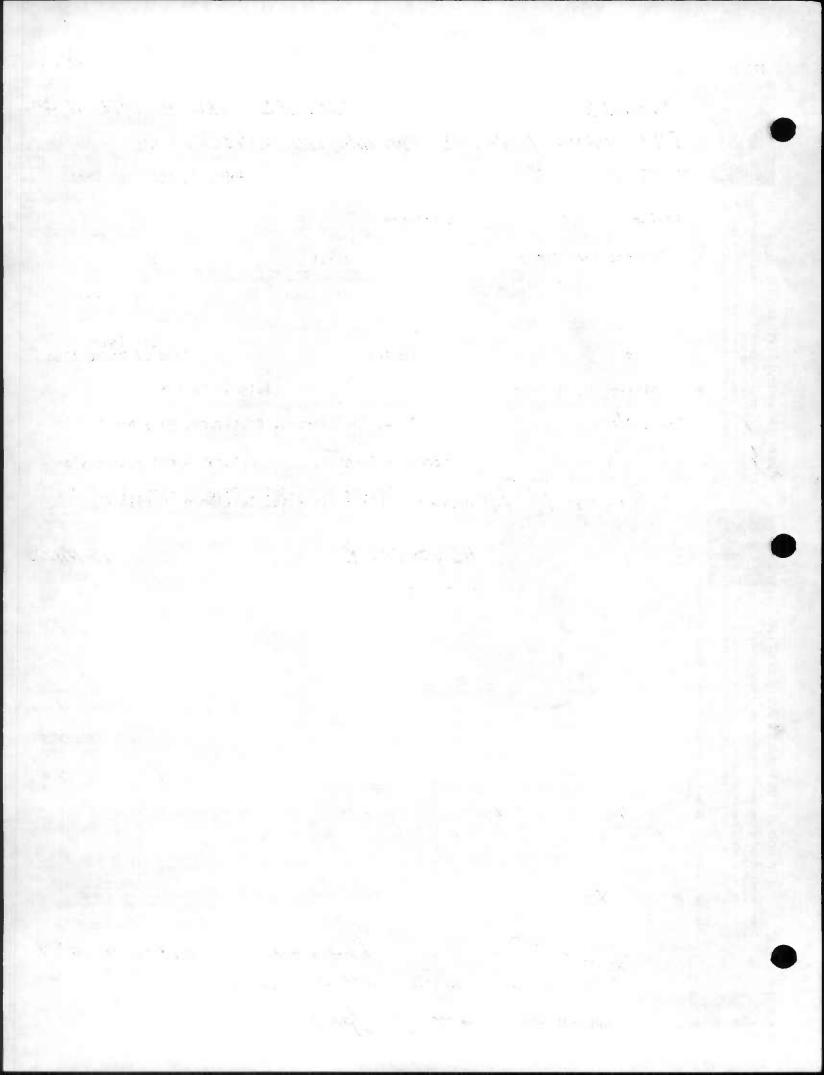
HOSPITAL

29d. Data signed (Month, Dev. Year)

32. Ragistrar's Signatura

JOHNS

To the Vithin 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedant's Nama (First Middle Last) 2. Data of Death **Physician** WHEATLEV 2:30 P.M 1999 4b. City, Town, or Location of Death /Medical 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner m.D HOSPITAL SAMARITAN If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, 5. Social Security Number Birthplace (Stata or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** 1 M 2□ F Months Days Yrs. 293-01-7547 Director Maryland Usual Rasidanca of Dacedant with the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-1 show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiena. Important if item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Macical Example could be not the 1 Yas 2 No Directo Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3018 Willowby Road 21234 United States Funeral 12. Was Dacadant Evar in U,S. Armed Forcas? 1 ⊠ Yas 2 □ No If Yas, Giva Yaar or Datas: ₩₩ II Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Nevar Marriad 2 Married 1□ Yas 2No Specify: ğ 3 Widowad 4 Divorced White 15. Decedant's Education (Spacify only highast grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done duning most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Union Sheet Metal Worker 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Harry Wheatlev Melissa Westbrook 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Lawrence Wheatley / Son 19450 Old York Road White Hall, MD 21161 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4/30/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Holy Redeemer Cemetery Mitchell-Wiedefeld Funeral Home, Inc. teven! 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in death) CHF Examiner Examiner The law requires that the death certificate be executed ettending physician end for use es the burial-transit Sequantially list conditions, if any, laading to Immadiata cause. Enter Undarlying Cause (Disease or injury that initiated avants rasulting in death) Last ATRIAL + VENTRICELLAR Division of Vital Records, P.O. Box 68760, Physician/Medical TOBACCO ABUSE been signed by the should be datached Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Qld tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? Completed s certificate has by diractor, page 2 sf 1 ☐ Yas 2 ☐ No or Attanding Physician: diractor, 25. Was casa rafarred to medical axaminar? Be 26. Placa of Daath (Chack only ona) 1 Yas 2 No Hospital: 1 Inpatiant Other: 4 Nursing Homa 5 Rasidence 6 Othar (Spacify) Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Mannar of Death 28d. Dascribe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 1 Natural
2 Accidant 5 Pending invastigation 124 hours after death.

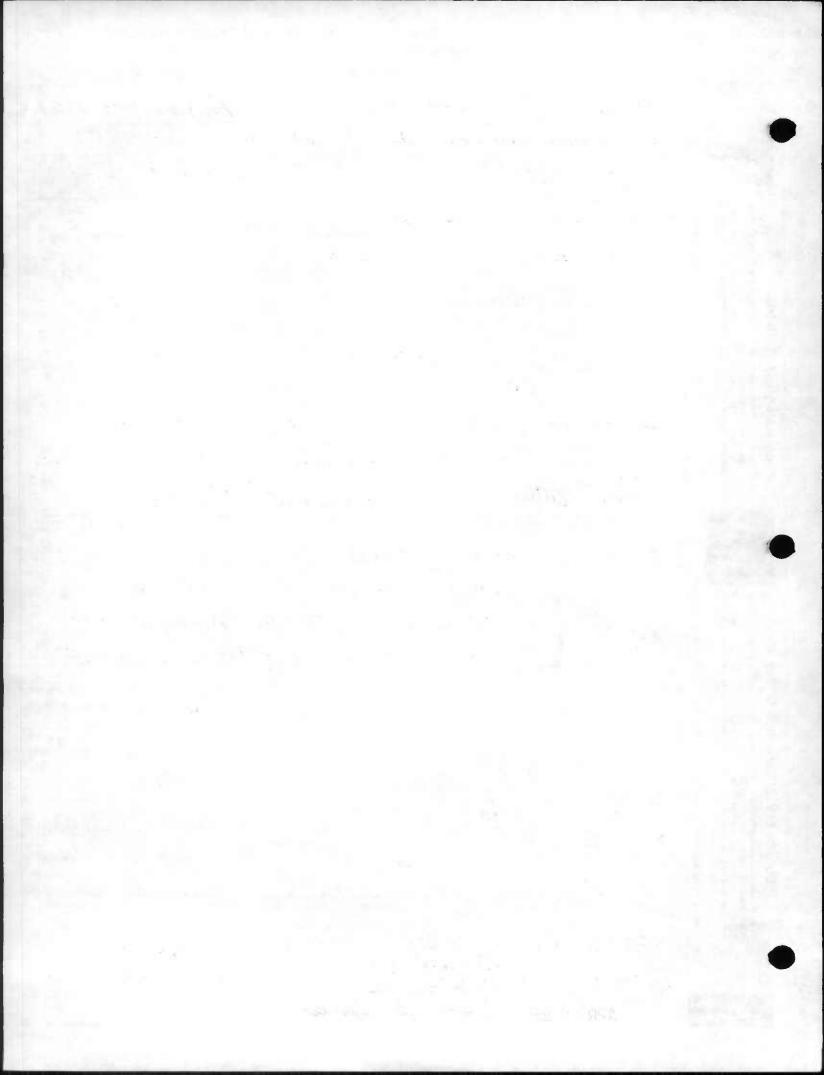
Funeral Offector: Af death. 1 ☐ Yas 2 ☐ No 6 Could not ba datemined 3 ☐ Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 4 ☐ Homicida 29a. Cartifiar edical Certifyling Physician: To tha bast of my knowledga, daath occurrad at tha tima, data and place, and dua to tha causa(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signad (Month, Day, Year) 29c. Licansa number 30. Name and address of person who complete

State Registrar 31. Data filed (Month, Day, Yaar)

APR 3 0

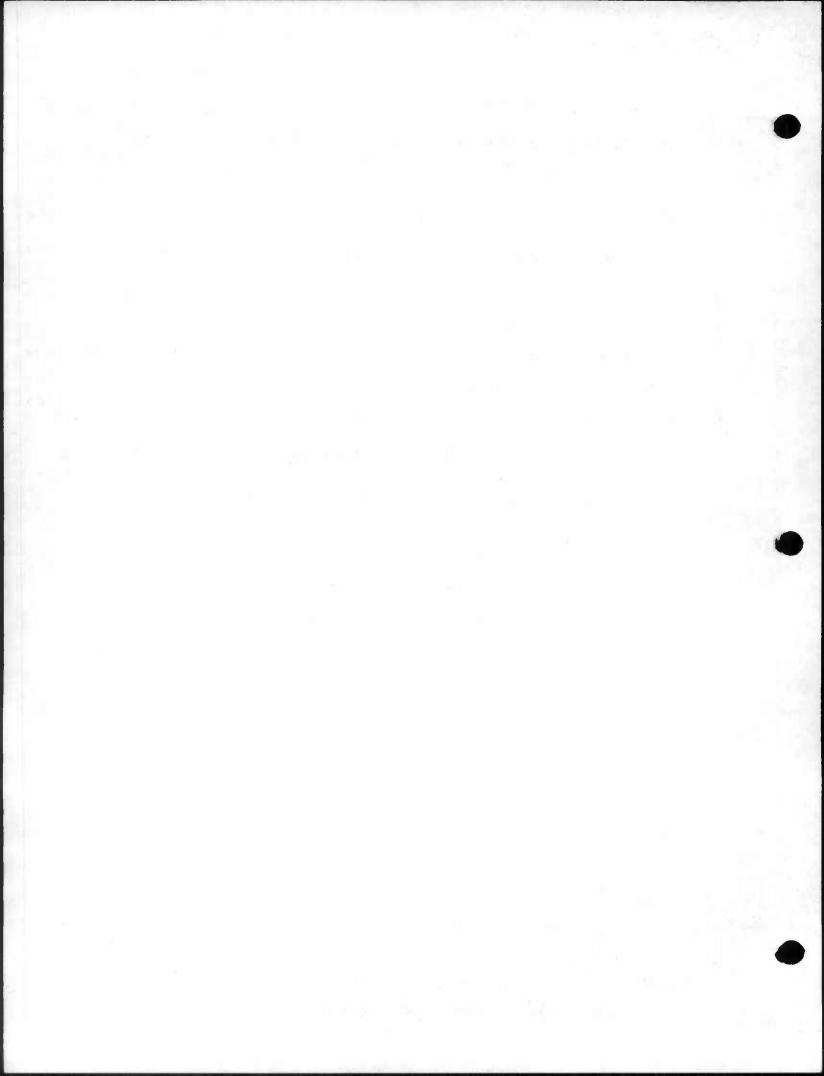
32. Registrar's Signature

B. Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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	Physic /Medi		Sarah E. Watkins									APRIL	Day 26	1999	02	45			
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	Funeral Director		5. Social Security Number 218-22-595	6. Sex	/ 2□ F	7. Age (In yrs. 82	last birthday) Yrs.	If Under 1 Months	Deys	If Under:	Min.	Dete of Birtle (Month, Day 01-11	(, Year)	9. Birthpl Count S	'ry)	e or Foreign			
	and w		Usual Residence of Decedent 10e. State 10b. Cou	ntv		10c. Ci	ty, Town or Lo	ocation						10	d Incide	City Limits			
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of \	hysic this c	ို	1 ☐ Yes 2 ☑ No				ER/Outpetier			4 LAPINUI			ence 6 Oth)				
Attending Physician of Vital Records, P.O. Box 68760, Attending Physician of Vital Records, P.O. Box 68760, Attending Physician of Vital Records, Maryland 2121 Department of Health and Mental Hyginian and September 18 marked other than a standard or the standard other than a standard or the standar	Affer I	ion:	27. Menner of Death 1 ☑Natural 5 ☐ Pen		28e. Dete of (Month	Injury , Day Year)	28b. Time of Injury		c. Injury Work			d. Describe h	ow Injury occur	red					
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Ď	5 4 5 E	Certification:	4 ☐ Homicide dete	mined	building	g, etc. (Specif	ome, ferm, str	eet, factory,	опісе		28	City or Tow	treet end Numl n, Stete)	oer or murei	Houre No	imber,			
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Certifier 1 Certific (Check only one) 1 Medic	ring Physici al Examiner	an: To the bas on the bas	ils of examine	wledge, death tion end/or in	occurred et restigation, in	the time	e, dete end inlon, deat	d plece, en th occurred	d due to the c et the time, d	euse(s) end ma ate end place,	anner es ste end due to	eted. the ceuse	e(s)			
	withir To th	Me	29b. Signeture end title of certi	ier				29c.	License	number		2	9d. Date signe	d (Month, D	ey, Yeer)				
			Thou	Testi					03	64194	1		41	7179	7				
			30. Name end eddress of person		pleted ceuse		23a) (Type,	Print)	harl	as st	- Ba	Ihmac a	צוני מוז	30					
	Sta Registr		31. Date filed (Month, Day, Yes	0 1999	32. Re	strer's Signe	giure &.	Sp	ak.	2			21 A 1 A						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Year Florence R. Weddington APRIL 26.1999 7:45 AM 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore If Under 1 Yaar Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-15-38 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign Min Country) 219-38-3185 XXM 2 F Hours 60 Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits NA Baltimore X No Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 1628 Lockwood Road 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) in & out of home 9th Grade NA Housekeeping 17. Father's Nama (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname)

Virginia

King Mem. Park Cem. 05-01-99

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3828 Beehler Avenue Baltimore, MD. 21215

Jefferson

Randallstown, MD

20c. Location - City or Town, Stata

Physician /Medical Examiner

certificate be executed

Box 68760,

P.O.

Division of Vital Records.

permit. Peges 1 and 2 sh Department of Heeith and Important: if item 27 is m any injury or other traum page.

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

10a State

MD

William

Helen

20a. Mathod of Disposition

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

Outten

1 M Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata

Lane

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

32. Registrar's Signature

G. BURNS, M. D.

31. Data filed (Month, APR 3 0 1999

Funeral

Director

the Maryland

d 2 should be filed within 72 hours after deeth with the Manylan Ih and Montal Ihyglene. 7 is marked other than "natural", or Rema 23a or 28a-f ahow traumatic event, in Medical Examples inclined as

Baltimore, Maryland 21215-0020

attending physician and for use as the burial-transit signed by the certificate has

Examiner Physician/Medical þ Completed Be 2 Certification: Al or Attendesth.
Arai Director: Afr filled in by

Baltimore, 21. Signature of Funaral Service Licensee Maryland 21202 22. Name and Addrass of Facility WM.C.March F.H. 1101 E. North Avenue 20 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. **Approximata** erval Betw Onset and Death Immediata Causa (Final disaasa or condition resulting in death) ADULT RESPIRATORY DISTRESS SYNDROME Dua to (or as a consequence of) SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of) INFECTED GRAFT that initiated events rasulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yes 25. Was casa rafarred to medical axaminer? 26. Place of Death (Check only one) 1□ Yes 20 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending invastigation Injury 1 Yes 2 No 3 Suícide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier 29b. Signature and tigh of certifies 29d. Date signed (Month, Day, Year) 29c. License number 53607 4/26/99

20b. Place of Disposition (Name of cematary, crematory or other place)

Registrar

State

PAUL

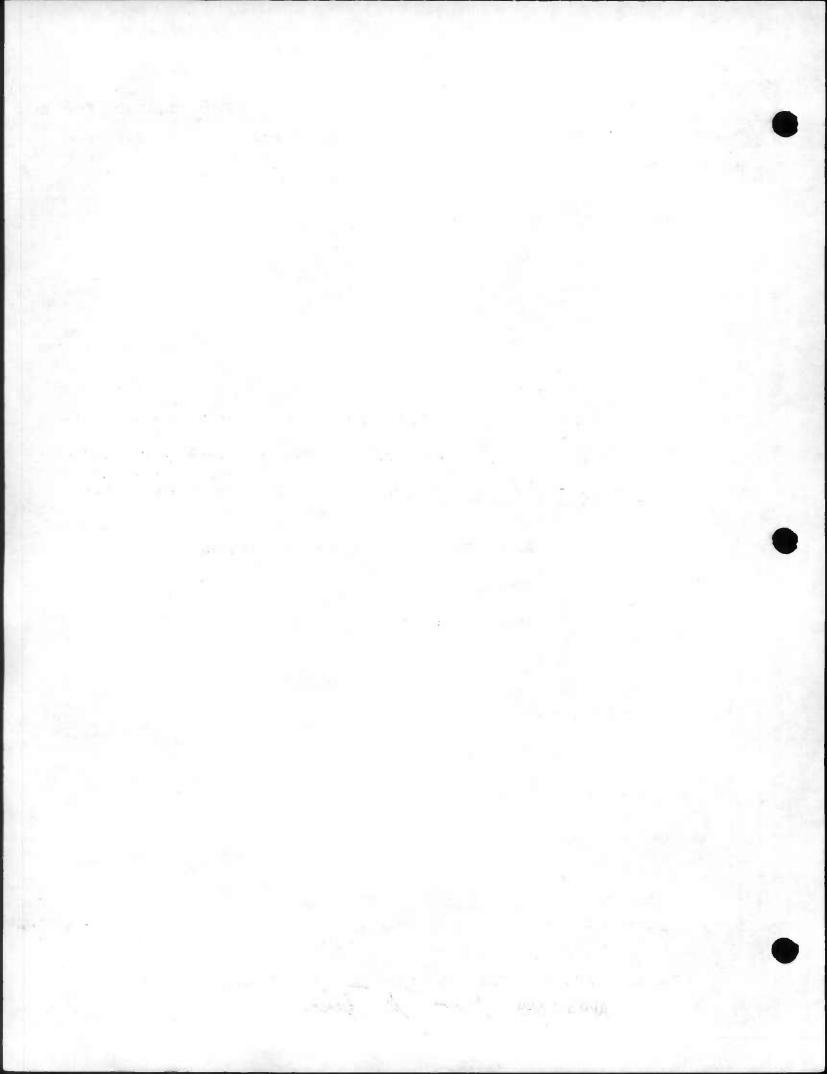
After this

Attending

To the Hospital o within 24 hours at To the Funeral Di

DHMH 16 Ray 6/95

7601 OSLER DRIVE TOWSON, MARYLAND 21204



DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

NOMACK

68760,

Box (

P.O.

Records,

Division of Vital

State Registrar

APR'3 **7**0 1999

ROBY. M.D. - 2211 32. Poistrar's Signature

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

W. ROGERS AVE. - BALTO MD

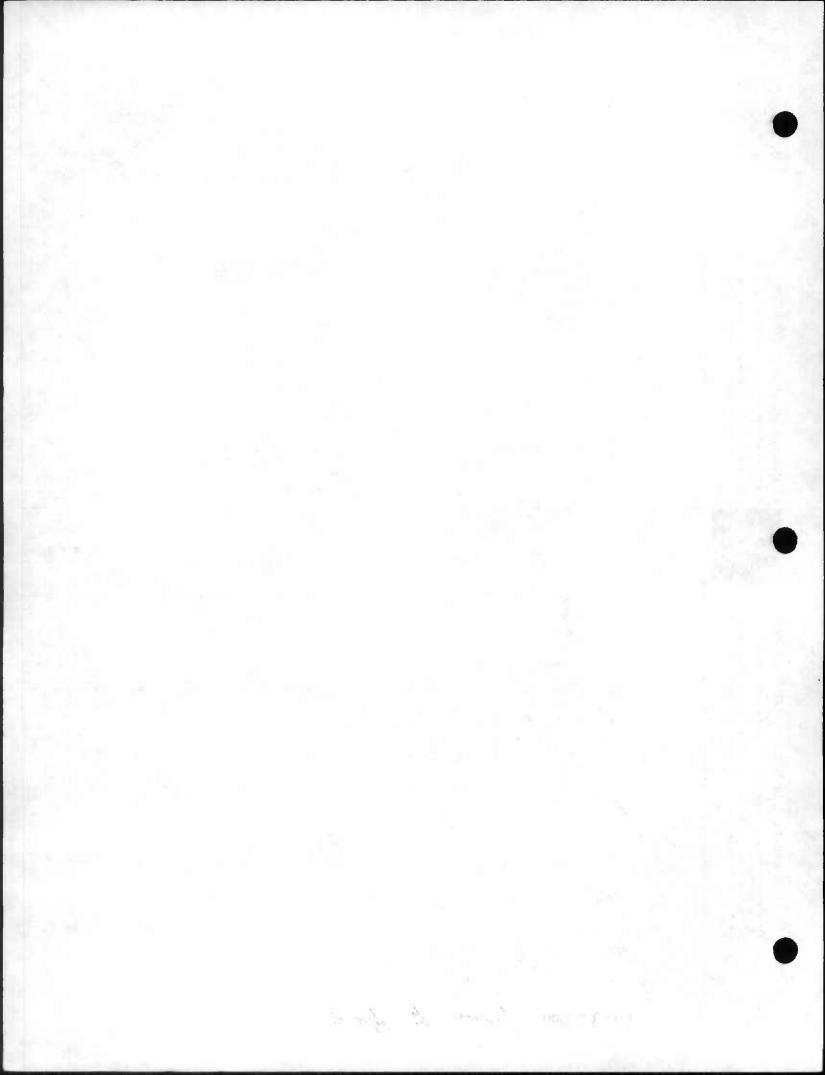
29c. License number

29d. Data signed (Month, Day, Year)

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Del	Reg. No. 99	3. Time of Death			
Physician	ALICE L. WAGNER	RIL 28, 199	9 5:30PM			
/Medical Examiner	4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of					
Examiner	JOHNS HOPKINS BAYVIEW BALTIMORE	N/A				
Funeral Director		e of Birth onth, Day, Year)	Birthplace (State or Foreign Country) VIRGINIA			
anyland ahow	10a. Stata 10b. County 10c. City, Town or Location		10d. Inside City Limits			
the Maryla 28a-f sho notified a	MD. N/A BALTIMORE		1 Yes 2 □ No			
O inter death with the Ma r items 23s or 23s-fs diest must be notified funeral Director	10e. Street and Number 10f. Zip Code 21 22 4	U.S.A.				
d 21215-0020 lied within 72 hours after death with the Maryland hygiene. ther than 'natural', or Items 23a or 28a-f show int, the Marical Examinat must be notified at the Completed by Funeral Director	If Yas, Giva ↑ 1 ☐ Yes 2 ☐ No Specify:	s or No- etc.) 14. Race- Black, Specify:	American Indian, Whita, etc. WHITE			
Maryland 21215-0020 d 2 should be filed within 72 hours aft th and Mental Hyglena. 7 is marked other than "natural", or traumetic avent, the Medical Exam To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WAITRESS	16b. Kind of Busin				
and 212 be filed withintel Hygiene. Ind other than avent, trail Be Comp	17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	Middle, Maiden Surname)				
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Maryle	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route					
C = N L	DORIS LEONARD/DAUGHTER 3901 HUDSON ST. BALTIN 20a. Mathod of Disposition 20b. Place of Disposition (Name of Pate					
Baltimore, pemit. Pages 1 ar Department of Haa important: If Itam; any Injury or other mice.	cemetery, crematory or other place)	99 GLEN BU				
ords, P.O. Box 68760, requires that the death certificate be executed requires that the death certificate be executed hould be detached for use as the bunal-transit and hould be detached for use as the bunal-transit eted by Physician/Medical Examiner	23a. Pant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respit shock, or heart failure. List only one cause on each line. Immediate Causa (Final disease or condition resulting in death) a. Pine M 3 1 is a Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Interval Between Onset and Death 2 4 Me Yes J			
daath daath daath daath do atte	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Sh. Did tobacco use contr	ibute to the cause of death?			
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S ≥ S E	Hypertension, temperalisteritis	a. Was an autopsy performed?	24b. Were autopsy tindings available prior to completion of cause of death?			
The law sate has be page 2 s		1□ Yes 20 No	1 ☐ Yes 2 ☐ No			
r VITAL Present The yatclan: The secretificata director, pag	25. Was case rafarred to medical axaminar? A Hospital: 26. Place of Death (Chec	x only one)				
on or vita ding Physician: h. Antar this cartific funeral director, tion: To Be (1 Inpatient 2/AEN/Outpatient 3L DOA 4L Nursing Home 5	☐ Residence 6 ☐ Other escribe how injury occurred				
To the Hospital or Attending Physician Within 24 hours after death. To the Funeral Director: After this completaly filled in by the funeral di	3 Suicida 6 Could not be determined 28e. Placa of Injury - At homa, farm, street, factory, office 28f. Los	cation (Street and Number y or Town, State)	or Rural Route Number,			
M Hospit n 24 hour Ne Funera plataly filli	29a. Certifier (Check only one) Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to course at the time, date and place, and the time, date and the t	e to the cause(s) and mann e time, date and place, and	er as stated. d due to the cause(s)			
vithin To the compl	29b. Signatura and titla of certifiar	29d. Data signed (
	Jour 2. June 20001442	4-30-	79			
β 	30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print) 30. ST PAN PL #815 BAWO MD 212	02				
State Registrar	31. Data filed (Month, Day, Year) 32. Registrar's Signatura					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1999 9:30 PM Nina Weinik April 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Vantage House Columbia Howard if Under 24 Hrs. Hours Min. 5. Social Sacurity Number If Under 1 Year 6. Sax 7. Aga (In vrs. last birthday) 8. Date of Birth (Month, Day, Yaar) Birthplace (State or Foreign Country) Months Days 1 □ M 2 🖾 F Yrs. 087-16-8955 80 Nov. 28, 1919 New York Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1□ Yes PNo MD Howard Columbia 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5400 Vantage Point Road 21044 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Black, White, etc. 1 Yas 20 No If Yes, Give Yaar or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) New Jersey State Job Elementery/Secondary (0-12) College (1-4or 5+) Placement Counselor 17. Fethar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Benjamin Mattus Diana Kushnerou 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5400 Vantage Point Road, Columbia, MD Leonard Weinik/Husband 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) 4/29/99 Columbia, MD Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Takoma Funeral Home Theo some It. Dur 254 Carroll Street NW Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in deeth) necimonia ne bro vas culas Acciocui Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2⊠ No le Cril (Atua) 24b. Were autopsy findings available prior to complation of ceusa of deeth? 24a. Was an autopsy performed? 1 Yes Mo 26. Place of Death (Check only one) Hospital: Other: Discoursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

Division of Vital Records, P.O. Box 68760 Mospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certific

Physician

/Medical

Examiner

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Completed

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Director

7 is marked other than "naturel", or items 23a or 28a-f show treumetic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter death 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturel; or items 23s any Injury or other treumstic event, the Medical Examiner must page.

Physician

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Examiner

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funeral director.

Examiner

altimore, Maryland 21215-0020

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Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. þ Completed Be 25. Wes cese referred to medicel examiner? 1 Yes 22 No To. 27. Manner of Death 1 Death 2 Accident Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical

(Check only) 29b. Signature and title of Couling

29c. Licansa number

29d, Date signed (Month, Day, Year) GALL 30, 1999

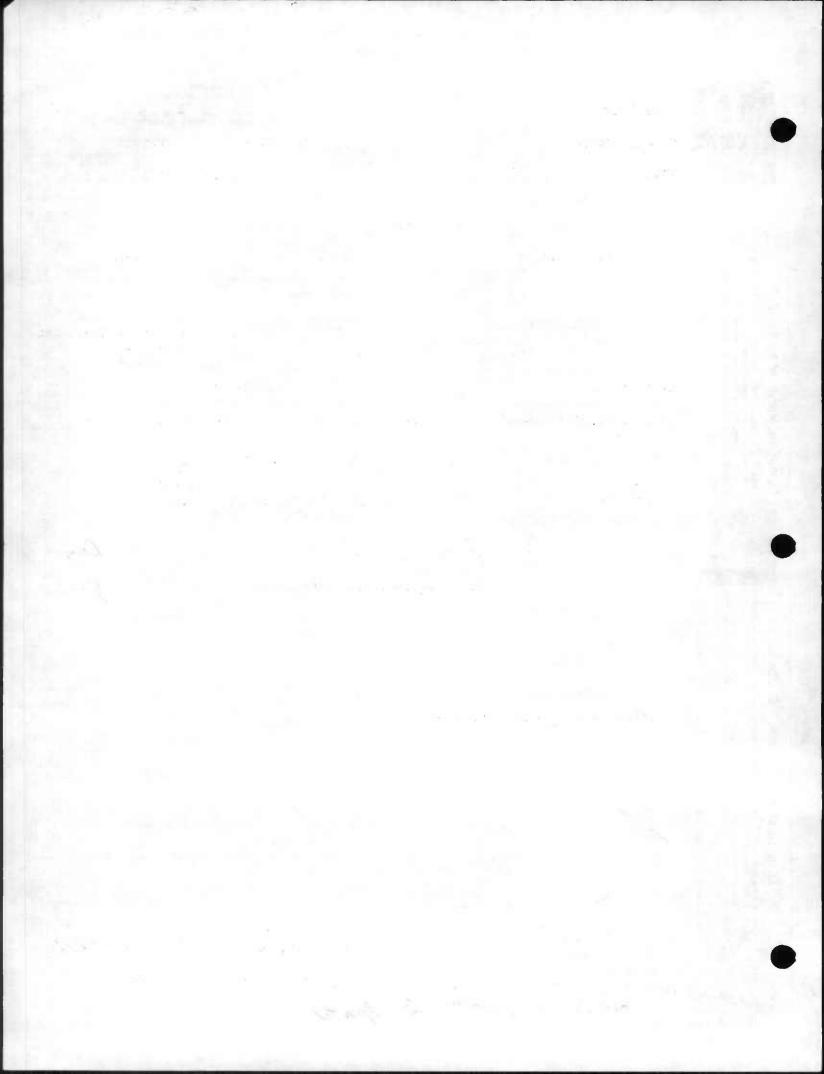
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

11055 Ltl. Patuxent Pkwy. #104 Columbia, MD 21044 Jerry Levine, 31. Date filed (Month, Day, Year) MD

State Registrar



To the Hosp within 24 hos To the Fune completely fi



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Month Day 10,00 AM Rose Teresa Yarnell Apr. 20,1999 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 612 S. 48th Street Eastpoint Baltimore If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (Stete or Foreign Country) Days Min. Months Hours 217-07-4264 80 Apr. 25, 1918 New York Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. 1□ Yes 2□Xio Baltimore Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 612 S. 48th Street 21224 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ♥Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8TH Seamstress Clothing Factory 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Spizowski Mary Drag 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelso Yarnell, Jr. /Son 161-1 Oko St., Koula, Hawaii 96734 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 4-28-99 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Laurel, Md. Balto.-Wash-Crematory 21. Signeture of Funeral Service Licensee 22. Nems and Address of Facility Bradley-Ashton-Matthews Funeral Homer, 2134 Willow Spring Rd., Balto., Md. 21222 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset end Deeth Immediete Ceuse (Finel heavet disease or condition resulting in deeth) Lulais que to (or es e consequence of): Physician/Medical Examiner ears Mitral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tohecco use contribute to the cause of death? 1 Yes 2 Olo 3 Probably 4 Unknown mellitis Diapeter þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 No Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Yes 2 No 28e. Date of Injury (Month, Day Year) 28b. Time of 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide

ician and burial-transit Box 68760, The law requires that the death certificate be P.O. Records, of Vitai Physician: Division or Attending

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nt of Health a If Item 27 is or other tra

Physician /Medical

Examiner

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Pages 1 and 2 should

72 hours after

21215-0020

Baltimore, Maryland

this Aftar within 24 hours after death. To the Funeral Director: A tha filled in by \$

DHMH 16 Rev 6/95

State Registrar

31. Dete filed (Month, Dey, Year) APR 3 0 1999

B' Mahony

(Check only one)

29b. Signature and title of certifier

30. Name and andress of person who completed cause of deeth 201 32. Registrer's Signeture

m 23a) (Type, Print) and

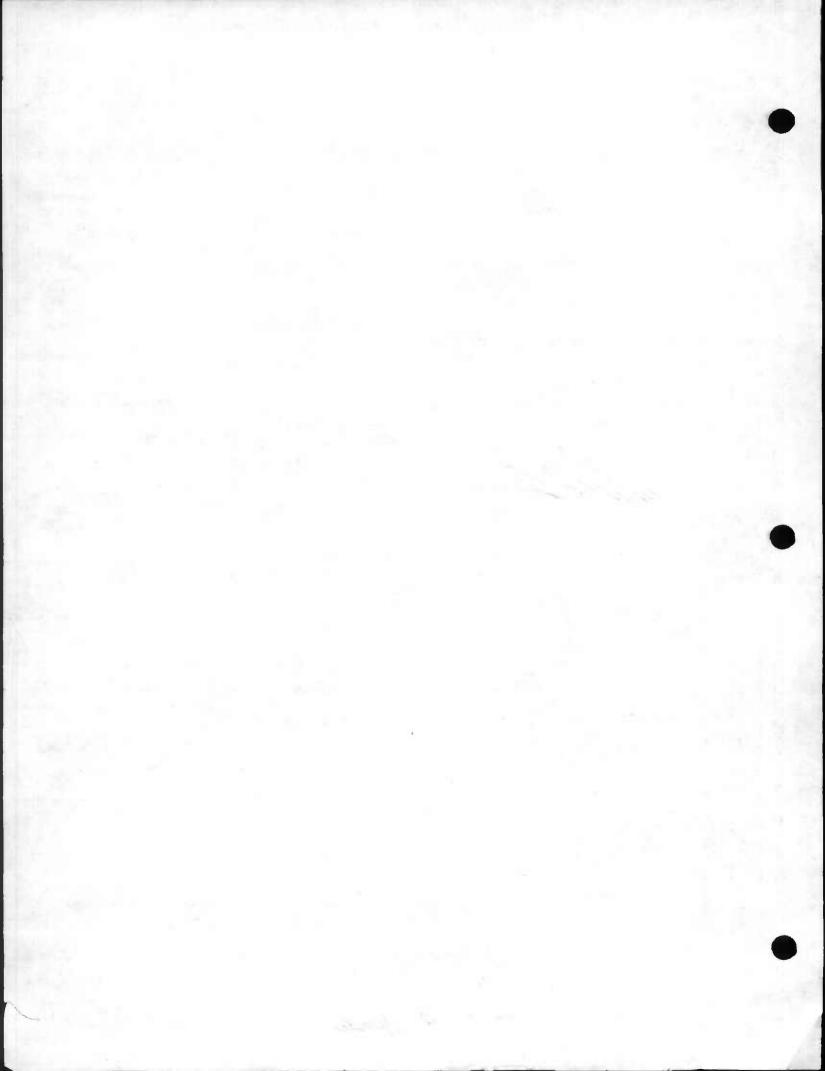
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

29c. License number

Baltimor, MD 21202

29d. Date signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Yaar Thelma Alvarez 3:57 P.M. April 5, 1999 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Chever1v Prince George's Hospital Center If Under 24 Hrs. If Under 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Hours Days 1 M 2 K 60 Yrs. 223-06-0548 Guatemala July 17, 1938 Usual Rasidenca of Decedent 10a. Stata 10d, Insida City Limits 10b. County 10c. City, Town or Location Alexandria Virginia XXYes 2 No 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda U.S.A. 3118 Brosar Court 22306 Was Decedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Black, Whita, atc. 12. Was Decedent Evar In U.S. Armad Forces? 11. Marital Status 1 Yas 2 No 1 Nevar Married 2 Married 1XXYas 2 No Specify: Specify: Spanish 3 Widowed 4 Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Custodian 12th grade 18. Mothar's Nama (First, Middle, Maiden Surneme) 17. Father's Nama (First, Middle, Last) Celia Calderon Luis Alvarez 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass *(Street and Number or Flural Route Number, City of Town, State, Zip 9452*1 4394 North Winterberry Court Cuncord, California Irma F. Johnson (COusin) 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Burial 2 Cramation 3 Ramoval from Stata 4/9/99 Beltsville, Maryland Chesapeake Crematory, Inc. 4 □ Donation 5 □ Othar (Specify) re of Funeral Service Licensee 22. Railands Funeration, Inc. 4339 Hunt Place, N.E. Washington, D.C. CUSTR nt1. Entar the disease, or complications that causad tha death. Do not entar the mode of dying, such as cardiac or respiratory arrast lock, or heart failure. List only one causa on each lina. Approximata Intervel Between Onset and Death Anema Immadiate Causa (Final disaasa or condition rasulting in daeth) Due to (or as a conseguanca of) 4 days Carcinona Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaasa or injury that Initiated evants rasulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying course given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to complation of causa of death? 24a. Was an autopsy performed? 2 No 1 Yes 2XXNo 1 Yas 25. Was casa rafarred to madical axaminar? 26. Pleca of Daath (Check only one) Othar: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatiant 3 DOA 28e. Dete of Injury (Month, Dey Year) 27 Manner of Deeth 28b. Tima of 28d. Dascribe how injury occurred 28c. injury at Work? 5 Panding investigation 1 Yes 2 No 2 Accidant

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

7 is marked other than "natural", or flems 23s or 28s-f show traumedo event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Med call Evant

Baltimore, Maryland 21215-0020

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death

Examiner Physician/Medical by Completed Be 2 Certification:

ettending physician end for use es the bunef-transit certificate be executed signed by the e pege 2 has certificate or Attending Physician: director. After this funeral death. ofter death

Division of Vital Records, P.O. Box 68760, filled in by Hospital 24 hours npletely To the To the F

29a. Certifier (Check only onel 29b. Signatura and title of cartifian

3 Suicide

4 Homicide

6 Could not be determined

1 Cartifying Phyalclan: To the best of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) end menner es steted.

2 Madical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29c. License number

D43662

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

3001 Hospital Drive Cheverly, Maryland 20785 William Boyce, M.D. 31. Data filed (Month, Dey, Year) 1999

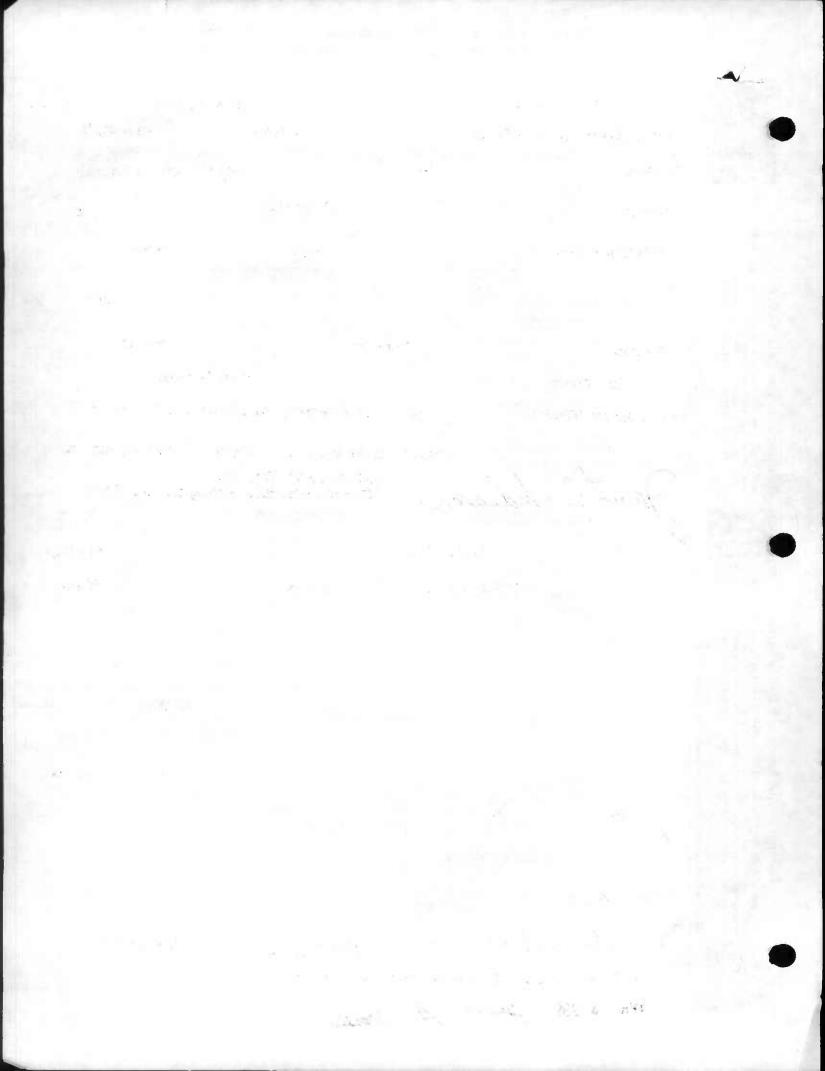
28e. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

State Registrar

Medicai

22. Ragistrar's Signatura

Sparke



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Lucious Anderson, Sr. 13,1999 April 10:15 A.M. 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Min 1X M 2□ F Months Davs Hours Yrs. 249-03-3971 86 4/12/13 S. Carolina Usual Residence of Decedent 10h Counts 10c. City. Town or Location 10d. Inside City Limits D.C. N/A Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5345 Chillum Pl., N.E. 20011 U.S.A. 14. Race - American Indien. 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 20XMarried 1 Yes 2K No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Skilled Laborer U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ransom Anderson Serena McKnight 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ruth Anderson/Wife Same as # 10 above 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 □ Cremation 3 □ Removal from State Harmony Mem. Park 4/19/99 Landover, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. 20019 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) andiomyorathi ears. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 9 Unknown shalo bathy 24b. Were autopsy findings available prior to completion of cause of death? Chround on Structive performed? 4 Jun. Disear 1 ☐ Yes 2 14100 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

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7 is marked other than "natural", or items 23s or 28s-f show trainmatic event, the Medical Examinar must be notified as

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death.

Depend and 2 should be filed within 72 hours effer deal Dependment of Health and Mentel Hygiene.

Important: If item 27 is marked other the any injury or other traumers.

physician and s the buriel-trens 98 use signed t pege 2 hes

After this 24 hours efter death.

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

To the To the To the I

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28b. Time of

28c. Injury at Work?

1 Yes 2 No

Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

2 Accident

4 Homicide

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of cartifier

29c. License number

29d. Date signed (Month, Day, Year)

APR 1 6 1999

5 Pending

investigation

6 Could not be

48213

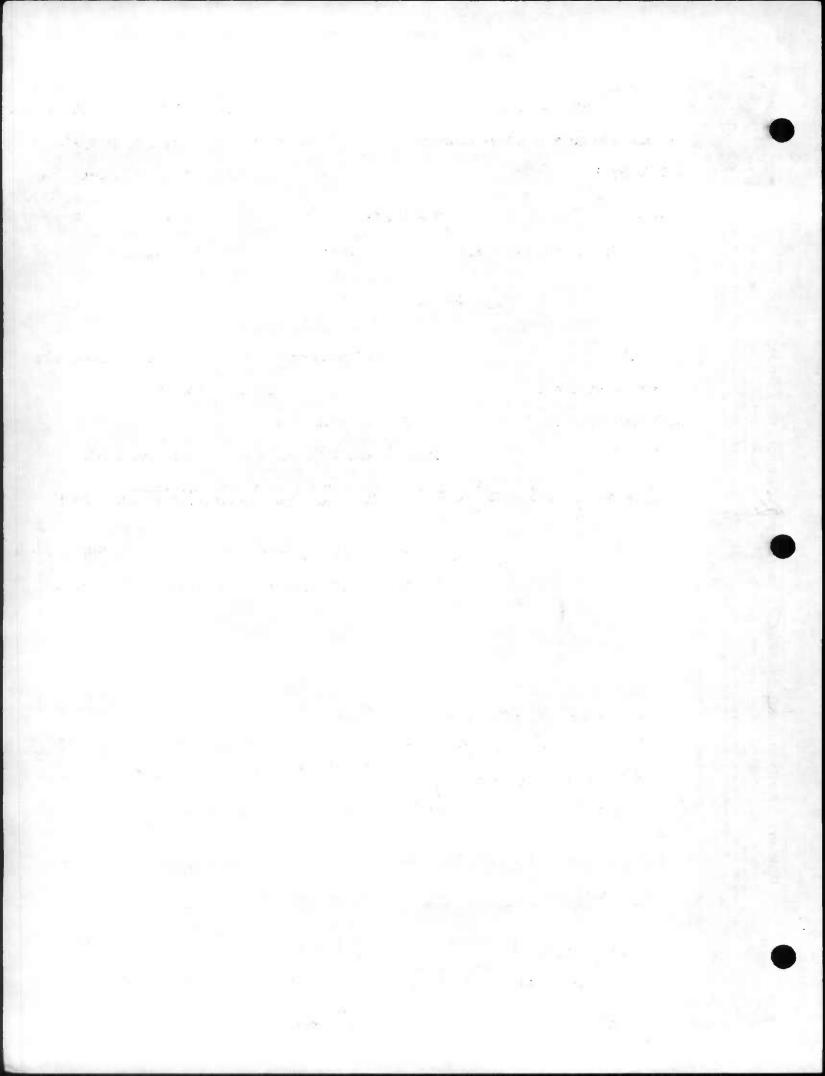
4-14-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IAH2A

4000 Mitchelulla # 220 Bowie HD 20716.

State Registrar 31. Dete filed (Month, Day, Year)

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 1.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Month **Physician** Thomas D. Alden, III April 12, 1999 3:15PM /Medical 4a Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 9631 Dewmar Lane Kensington Montgomery 6. Sex 1 M 2 F If Under 1 Year 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Min. Months Devs Hours 56 Yrs. December 6,1942 Connecticut Director 087-36-0252 10d. fnside City Limits with the Merylend 10a State 10h County 10c. City. Town or Location must be notified at 1 ☐ Yes 2X No Directo Maryland Montgomery Kensington 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 9631 20895 Dewmar Lane United States Funeral death 7 is marked other than "natural", or items traumatic event, the Wedical Examiner na 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status filed within 72 hours efter 1 Never Merried 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify by If Yes, Give Yeer or Detes: 1962–1964 3 ☐ Widowed 4 ☐ Divorced White Completed Decedent's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) 12 Attorney Law 18 Mother's Neme (First Middle Maiden Sumame) 17. Fether's Neme (First, Middle, Last) . Pages 1 and 2 should be filt ment of Health and Mental Hy ant: If them 27 is marked oth jury or other traumatic event Thomas D. Alden, II Mercedes Ahern 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 9631 Dewmar Lane, Kensington, Maryland 20895 Coralyn Colladay-Wife Baltimore, 20b. Pleca of Disposition (Neme of cemetery, crematory or other plece) Date 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlal 2 2 Cremation 3 ☐ Removel from Stete permit. Page Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Crematory 4-15-99 Brentwood, Maryland 21. Signeture of Foreral Service License 22. Name end Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, Maryland 20722 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final diseese or conditio resulting in death) week Examiner Due to (or es e consequence of): Examiner Duct Lanoma physician end the burief-trens Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of) that the death certificate be exec P.O. Box 68760. Physician/Medical Due to (or es e consequenca of): 98 USB Ö signed by the eld be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uea contribute to the causa of death? 1 ☐ Yas 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy been performed' pege 2 1 ☐ Yes 2 No 1 TYes 2 □ No. certificate or Attending Physician: efter deeth. Director: After this certifice director, 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpetient 3 DOA funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of Certification: 28c. Injury et Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To The Hospital or within 24 hours aft To the Funeral Di completely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. edical 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29d, Dete signed (Month, Dev. Year) 29c. License number April 15, 1999 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) James D. Ahlgren, M.D. 2150 Pennsylvania Ave., N.W. Washington, D.C. 20037 31. Dete filed (Month, Day, Yeer)
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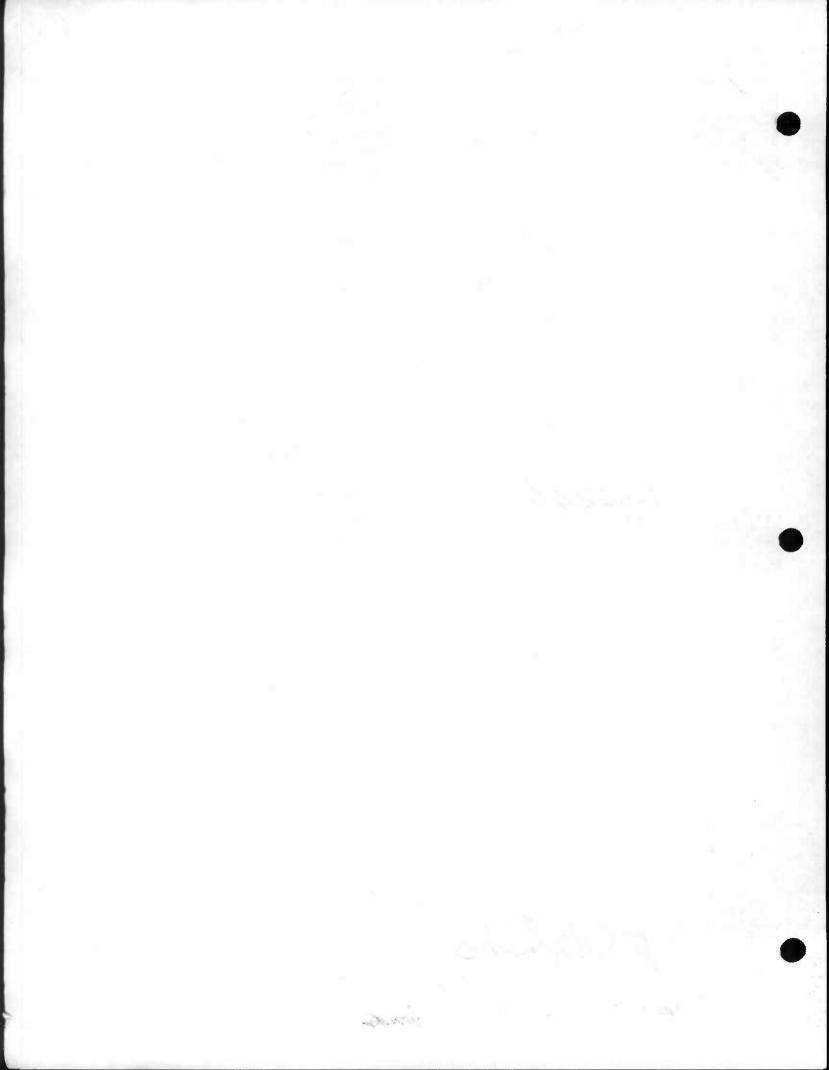
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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death APR Armstrong 0545 A 09 nez 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Columbia Nursinghome Howard Lorien If Under 24 Hrs. Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 □ M 2 F 89 Yrs. June 10, 1909 Washington DC 110-10-7668 10b. County 10c. City, Town or Location 10d. Inside City Limits N Yas 2 No N/A Washington 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20002 649 Acker Street N.E. U.S.A. 11 Marital Statue 12. Was Decedent Ever in U,S Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Yas 27 No If Yes, Give Yaar or Dates: 1 Nevar Merried 2 Married 1 ☐ Yes 2√☐ No Specify: Specify: Black 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th Elevator Operator Urban League 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Emma Gant Alexander Vass 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4817 Wood Rd., Temple Hills, MD 20748 Rev. James Armstrong - Son 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Ramovel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Lincoln Memorial Cemetery 4-15-99 Suitland, MD 22. Name and Address of Facility Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licenses laws 4217 9th Street N.W. Washington, DC 20011 23a. Part / Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, show, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death ierebrovascular Accident 6 Months Immedieta Cause (Final disease or condition resulting in deeth) Due to (or as e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that inflieted avents resulting in death) Lest Due to (or as e consequence of): Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Kespinatory 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Ware eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 20 No 1 ☐ Yas 2 ☐ No

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

Physician /Medical Examine

Physician

/Medical

Examiner

10a Stata

D.C.

Director

Funeral

2

Completed

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Funeral

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tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinat must be notified at

permit. Peges 1 and 2 should be filed withir Department of Health and Mental Hygiana. Important: if item 27 is marked other than any Injury or other traumatic event

the Maryland

72 hours efter

Baltimore, Maryland 21215-0020

Examiner burial-transit Physician/Medical à Completed Be

25. Wes case referred to medical examinar?

29b. Signature end title of certifiar

1 Yes 2 No

27. Menner of Deeth

1 Neturel 2 Accident

3 ☐ SuicIde

29e. Certifier

4 Homicide

(Check only one)

and physician a certificate 10 this efter death. Director: After t Certification:

Division of Vital Records, P.O. Box 68760. or Attending

To the Hospital or within 24 hours effer deat To the Funeral Director

Medical

Registrar

SANJAY P. SHAH, MD 10805 Hickory LidgeRd #210, Columbia, MD210 31. Dete filed (Month, Day, Year) APR 1 4 1999

Hospitel:

5 Pending Investigation

6 ☐ Could not be

28e. Dete of Injury (Month, Dey Year)

P. Shah, M.D.

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

1 Inpatient 2 ER/Outpatient 3 DOA

28a. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

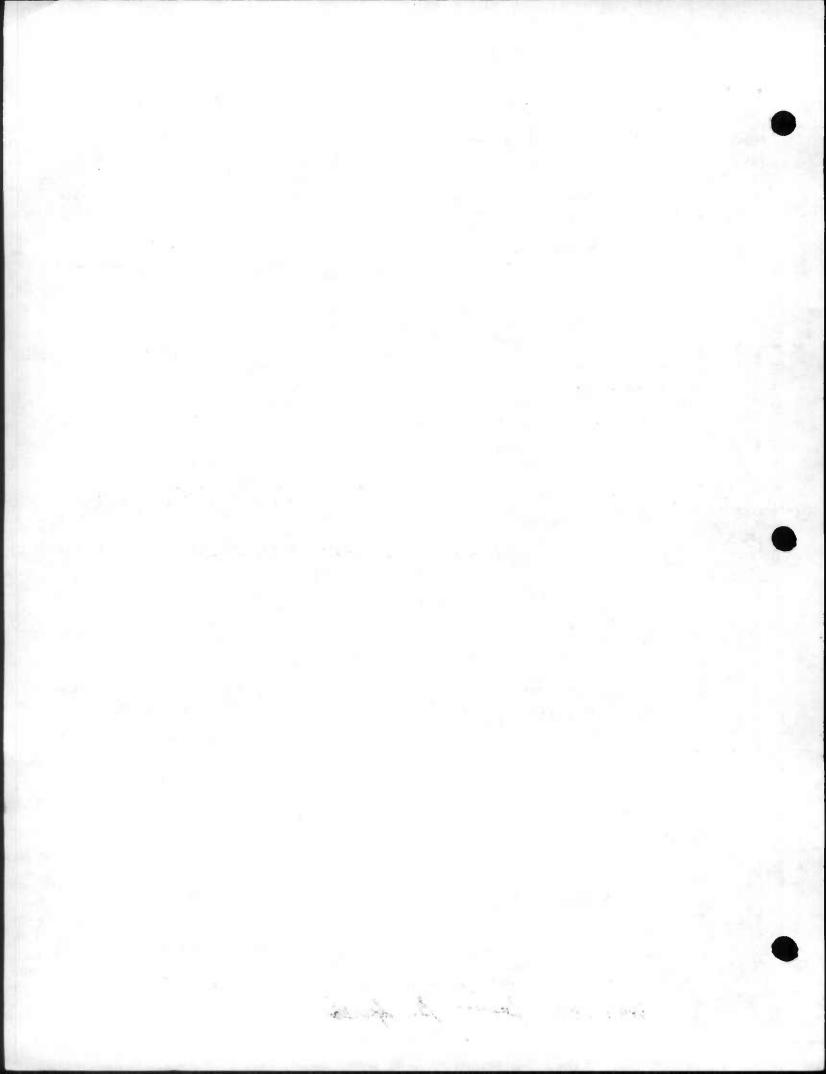
28c. Injury at Work?

120 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated.

29c. Licensa number

1 Yes 2 No

DO052940



Be Completed by Physician/Medical Examiner

Medical Certification: To

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1 Never Married 200 Married	Armed Fo	2 🔀 No		1 Tes, specify Cu		to Hican, etc.)		k, White, etc.
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De. Method of Disposition	۳۵	CO	ece of Dispernetery, cr	position (Neme of rematory or other pi	ece)	Dete 20	c. Location -	City or Town, State
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31. Dete filed (Month, Day, Yeer) FEB 2 5 1998

615 W. MACPHAIL 32. Registrer's Signeture

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Day APRIL 17, 1999 5:20 p.m. JUDITH ANN ALLEN 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth PRINCE FREDERICK CALVERT CALVERT COUNTY NURSING CENTER 6. Sex If Undar 1 Yaar If Undar 24 Hrs. Months Days Hours Min. 8. Dete of Birth (Month, Dey, Year) 9. Birthpieca (State or Foreign Country) March 18, 1939 Washington, DC 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🖾 F 579 50 5906 Yrs 60 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Calvert. Prince Frederick 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 1557 Old Adelina Road 20678 United States 14. Race - Amarican Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Detes: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Caterer Food service 17. Father's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Olga P. Gossett John W. Baxter 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11705 Zebra Wood Ct., Germantown, MD 20876 19e. Informant's Neme/Reletionship (Type, Print) Tammy Shrimpton/ daughter 20b. Plece of Disposition (Name of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriai 2 X Cramation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 4/19/99 Alexandria, VA Metropolitan Crematory 22. Name end Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funerel Service Licensee I Bell 4405 Broomes Island Rd., Port Republic, MD 20676 23e. Pert1. Entar tha diseese, or complications that caused the deeth. Do not antar tha mode of dying, such as cardiec or raspiratory arrast, shock, or heer feilure. List only one ceuse on each line. Approximete interval Between Onset and Death immediete Ceuse (Final diseese or condition resulting in deeth) SMALL CELL LUN6 CANCER Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting In death) Last Due to (or es e consequence of): Due to (or as a consequence of) Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown INSULIN DEPENDENT DIABETES 24b. Were autopsy findings aveilable prior to completion of causa of deeth? 24e. Wes an autopsy performed? 1 Yes 2€No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 | Yes 2 □ No 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? 1 Neturel 5 Pending

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

p

Completed

2

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner traust be notified at

permit. Pegas 1 and 2 should be filed within 72 hours efter death a Depertment of Health and Mental Hygiena. Important: if flam 27 is marked other than "natural", or Itema 23a any injury or other traumatic avant

3altimore, Maryland 21215-0020

Box 68760,

the Maryland

Examiner Physician/Medical þ Completed Certification: To

physician and s tha burial-transit need has funarai

Division of Vital Records, P.O. Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this carific filled In by tha compiately i within 2 To the

Registrar

State

edical

29b. Signatura and title of cartifier

investigation

6 Could not be determined

APR 19

2 Accident

4 Homicide

31. Data filed (Month, Day, Year)

3 ☐ Suicide

29e. Certifier

29c. Licansa number

15 Certifying Physictan: To tha best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TRINCE - tredeput MA 20678

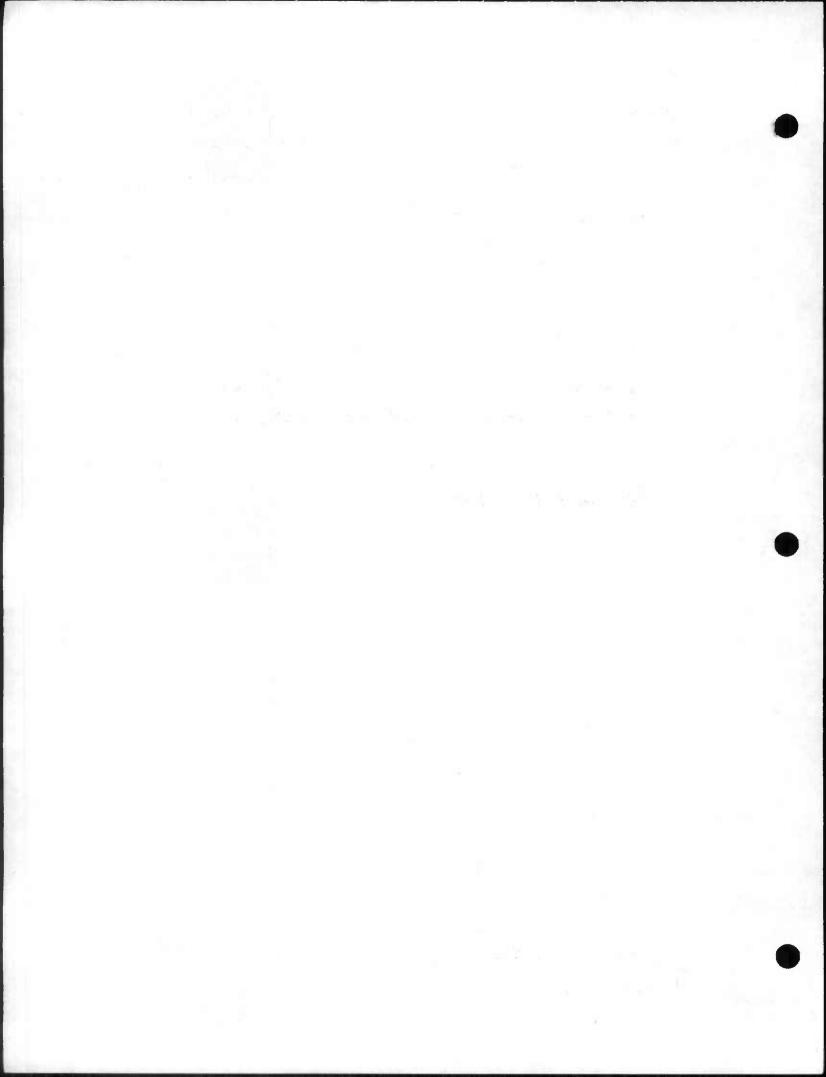
28f. Location (Street end Number or Rurei Routa Number, City or Town, Stefe)

ne end eddress of person who completed cause of deeth (Item 23a) (Type, Pript) Wisniewski, M.D. 110 Hospital

32. Registrer's Signatura

28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Yes 2 No



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedenf's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** MARIE THERESA ALLEN APRIL 13 1999 9:25PM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner CALVERT COUNTY NURSING CENTER CALVERT PRINCE FREDERICK 8. Data of Birth (Month, Day, 7. Aga (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 9. Birthplaca (Stata or Foraign **Funeral** Months Days Hours 1□ M 2⊠ F Yrs. Director 577-05-2160 83 MARCH 1. 1916 WASHINGTON, DC Usual Rasidance of Decedan the Maryland 10a State 10h Count 10c. City, Town or Location 10d. Insida City Limits show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Moulcal Examinar must be notified at 1 Yas 2 No Director MARYLAND ANNE ARUNDEL ROSE HAVEN 10e. Sfreef and Number 10f. Zlp Coda 10g. Citizan of What Country? 7055 CHARLESTON AVENUE 20714 U. S. A. death Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian. Biack, Whita, atc. 72 hours after Baltimore, Maryland 21215-0020 1 Yas 2√2 No Specify: Specify: by 3√Widowed 4 □ Divorced WHITE Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grade completed) pernit. Pagas 1 and 2 should be filed within: Department of Health and Mantal Hygiana. Important: if few 27 is merked other than "nany injury or other traumatic avant Elamentary/Secondary (0-12) College (1-4or 5+) U. S. GOVERNMENT 12 FEDERAL EMPLOYEE 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) 8 FRANK FRANCES (UNAVAILABLE) FUSCO 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 3206 SADIE LANE LA PLATA, MARYLAND 20646 KENNETH ALLEN / SON 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata APRIL 1 Burial 2 Cramation 3 Ramoval from Stata 4 □Donation 5 □ Other (Specify) 16,1999 WASHINGTON. DC ST. MARY'S CEMETERY 22. Name and Address of Facility LEE FUNERAL HOME CALVERT, P.A. 21. Signature of Fyheral Service Lic 8125 SOUTHERN MD BLVD, OWINGS, MARYLAND 23a. Party. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximata Onset and Death **Physician** /Medical Immediata Causa (Final CHF Weeks diseasa or condition rasulting in daath) Examine Dua to (or as a consequence of) Examiner C Ne physician and tha burial-transit Sequantially list conditions, if any, leading to immediata cause. Entar Undarfying Cause (Diseasa or Injury that initiated avants rasulting In death) Last Due to (or as a consaquance of) CAD Box 68760. Physician/Medical Dua to (or as a consequance of): attanding usa jo signed by the at d be datached for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 TYPE 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior fo completion of cause of death? 24a. Was an autopsy performed? Completed peed has 1 Yas 2 1 No 1 ☐ Yas 2 ☐ No certificata Division of Vital 25. Was casa rafarrad to medical Be 26. Place of Denth (Check only ona) Hospital: Othar: 4 Inursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 2 1 Inpatiant 2 ER/Outpatient 3 DOA this funaral 27. Mannar of Beath 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th complataly filled in by the funera Certification: 28b. Time of 28c. injury at Work? Aftar 1 Natural 5 Panding Invastigation 1 Yas 2 No 2 Accidant 6 Could not be datermined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 ☐ Homicida edical 29e. Cartifiar 1 🖫 Certifying Physician: To tha best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner etated. 29b. Signature and title of certifier 29c, Licansa number 29d. Data signed (Month, Day, Year) ardur wmar a 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) KIOUMARCE YAZDANI, M.D. 2555 SOLOMONS ISLAND RD., N. HUNTINGTOWN, MD

State Registrar 31. Data filad (Month, Day, Year)

APR 15

32. Registrar's Signatura

20. 2 E M

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day **Physician** Margaret Cecelia Brady April 25 1999 8:25 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1294 Lavall Dr. Davidsonville Anne Arundel If Undar 1 Yaar | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Data of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 M XXF Months Min 578 09 3461 85 Director Washington DC August 6 1913 Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Heelth end Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Exercise must be notifyed. 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 No Anne Arundel Davidsonville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21035 1294 Lavall Dr. United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Aeneas Collins Margaret Hannan 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)
1294 Lavall Dr. Davidsonville Md. 21035 19a. Informant's Name/Relationship (Type, Print) Gerald Brady SON 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Washington DC 4/25/99 4 Donation 5 ☐ Other (Specify) Washington Univ. Med.Ctr 22. Name and Address of Facility Columbia Mortuary Services 21. Signature of Funeral Service Licens PO Box 58007 Washington DC 20037 Na 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** artatie Immediate Cause (Final diseese or condition resulting in death) /Medical **Examiner** Examiner The law requires that the death certificate be executed · Sign physician end s the burief-trans Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 88 ettending p for use es ed by the deteched 23b. Did tobacco use contribute to the cause of death? Part fl. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 22 No 3 ☐ Probably 4 ☐ Unknown been signed to should be detr Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 hes 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerei 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural To the Hospital or Attending within 24 hours effer deeth.

To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es steted. edicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signature and title of cartifiar 29c. License number 29d. Datersigned (Menth, Day, Year)

State Registrar

DHMH 16 Rev 6/95

APR 3 0 1999

ST. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOCD

B. Sparks

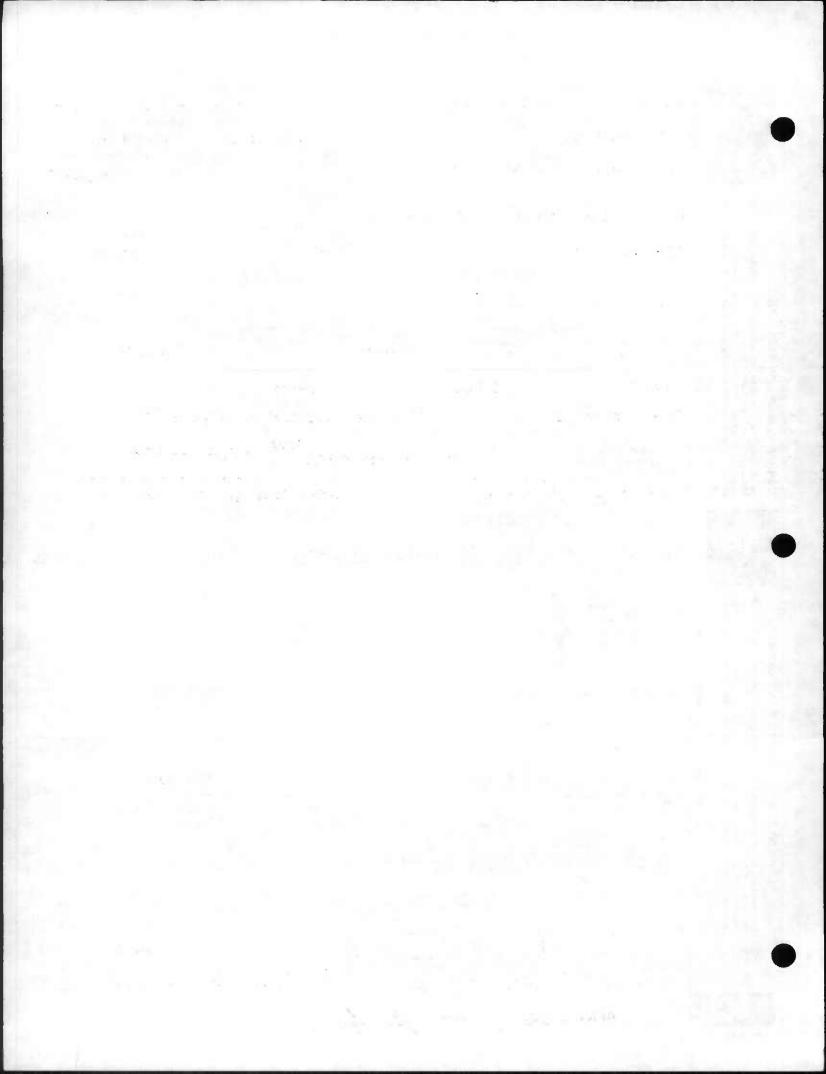
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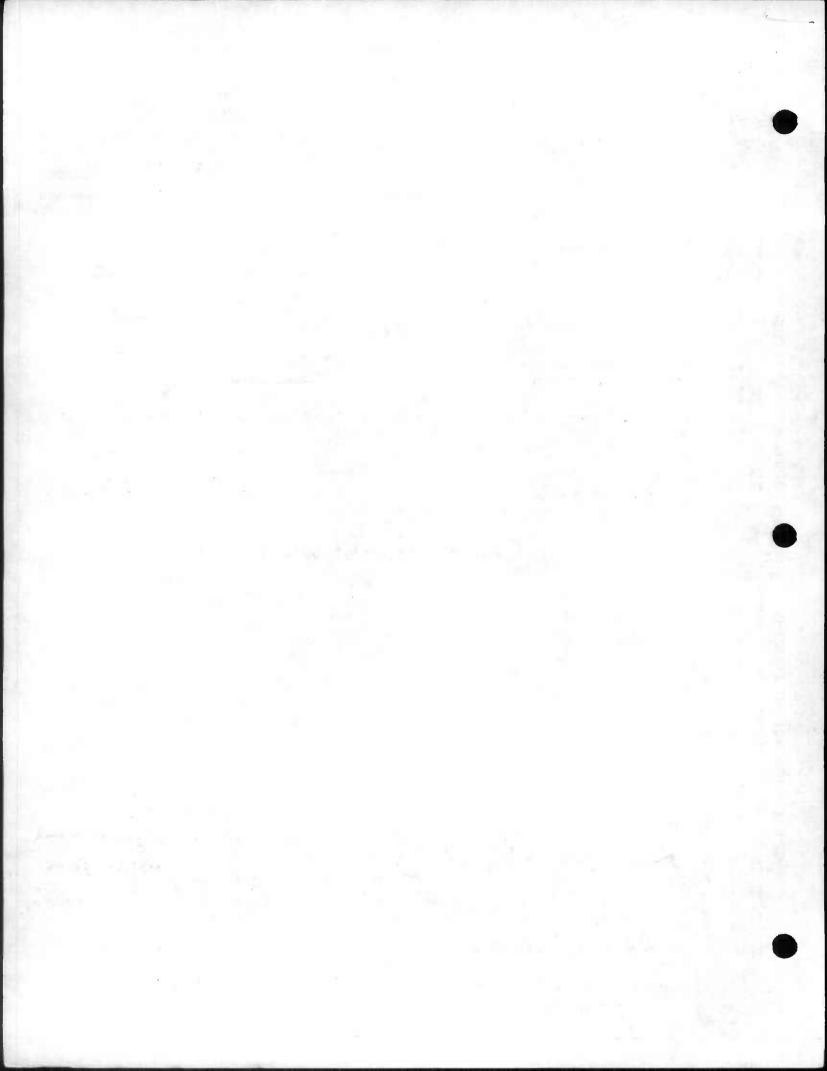
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Decedent's Name (First, Middle, Last)	1	Cer	tificate of	Death	2. Dete of De	Reg. No.	7 1 1
Jeanne W. I					Month	Dey	Year 3. Time (
4a Facility Name (If not institution, give				4b. City, Town, or	APRII.	03, 199 h 4c. County	
10709 ORDWAY DRIV				SILVER			OMERY
5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea Months Day	If Under 24 Hrs		th	9. Birthplace (State Country)
089-32-3314	M 2€ 59	Yrs.	Working Day	3 110013 14781	8. Date of Bir (Month, Da Sept	22, 1939	Washing
Usuet Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside (
Maryland Montgo	omerv s	Silver	Spring				1 □ Yes
IOe. Street and Number			10f. Zip Code			10g. Citizen of \	Whet Country?
.0709 Ordway Drive			209	01		Unite	ed States
1. Marital Status	Was Decedent Ever in U, Armed Forces?	S. 13. V	Was Decedent of Yes, specify Cu	Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No to Rican, etc.)		ce - American Indien, ck, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑No If Yes, Give	1	□Yes 201N	o Specify:		Specifi	
	Year or Dates:	16a Dagad	lante Heuel Oca	unntion			Black
15. Decedent's Educ (Specify only highest grade	e completed)	(Give	lent's Usual Occ kind of work don OO NOT use reti	upation le during most of wo red)	orking	TOO. AND OF B	usiness/Industry
Elementary/Secondary (0-12)	College (1-4or 5+) 5+		eacher			Educ	cation
17. Father's Name (First, Middle, Last)					me (First, Middle		
Marcellus A. Winsto	on			Eval I	lewe E	va L. Ho	owe
19a. Informant's Name/Relationship (Ty		The second second		et and Number or A			
Judith W. Richardso 20a. Method of Disposition							land 21044
1 ☐ Burial 2 ☐ Cremetion 3 ☐ R	emover from Stete		sition (Neme of netory or other p	and the same of th	Dete		- City or Town, State
4 Donation 5 Other (Specify)		ro Cre	matory		4-6-99		wille, MD
21. Signature of Funeral Service License	90	h Ha	. Name and Add	ress of Facility	Damille T		
		110	шту п.	witzke.s	ramity i	uneral	Home, Inc.
23a. Part1. Enter the disease, or complishock, or heart feilure. List only or Immediate Cause (Final disease or condition resulting in death)	Contact	Do not ente	.12 Old er the mode of d	Columbia	Pike Ell	rrest,	Approximatinterval Be Onset and
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					Certificate of	Death	Re	g. No.	14/15
	Dhusia		Decedant's Nama (First, Middla, Last)				2. Deta of Daat	h	3. Time of Death
	Physic /Medi		William W. Bri	esmaster,	Jr.		April 1	6, Day 1999	8:02 A.M.
	Examii		4a. Facility Nema (If not Institution, give street end no	imber)		4b. City, Town, or Lo	ocation of Deeth	4c. County of	Deeth
			14200 Livingston Road	l		Clinton		Prince	e Geroge's
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21215-0020	n 72 hours after death with the Maryland "natural", or items 23s or 28s-f show solicel Examiner must be notified at	by Funeral	1 Nevar Married XXMarried 1 Yas, 3 Widowed 4 Divorced Year or I	orcas?	13. Wes Decedant of If Yes, specify Cul		Rican, etc.)		whita, atc. White
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Maryland	01 00 00 00		19a. Informant's Name/Ralationship (Type, Print)		. Mailing Addrass (Stree				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** Mary Brewster April 14 1999 8:55 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Oxon Hill 124 N. Huron Dr. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In vrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M XXF 75 112 14 7740 Director January 21 1924 India Usual Rasidance of Decedant deeth with the Maryland 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits ahom Peges 1 and 2 should be filed within 72 hours after deeth with the Maryle neat of Health and Mentel Hygiens. Internet 23a or 28a-f show that Maryle or other than "natural", or fame 23a or 28a-f show yor or other traumatic avant, its shocks Examiner must be notified as Oxon Hill MD Prince Georges Director 1 ☐ Yas 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 124 N. Huron Drive 20021 United States Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☑ Yas 2 ☐ No KOrean If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, etc. 11. Marital Status 1 Nevar Married 2 Married 1 Yes 2 No Specify: SpecifyWhite þ 3 ☐ Widowed 4√Divorced Yaar or Datas: War Completed 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Computers Programmer 12 17. Fathar's Nama (First, Middla, Last) 18 Mother's Name (First Middle Maiden Sumama) Be Burkitt Clark Harrington Charlotte Frisch Jacobs 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 124 N. Huron Dr. Oxon Hill Md. 20021 Susan Brewster / Daughter 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State permit. Pege Department of Important: If any Injury or 2005. Washington DC 4 ☑ Donation 5 ☐ Othar (Specify) Washington Univ. Med. Ctr 4/14/99 22. Name and Address of Facility Columbia Mortuary Services 21. Signature of Fyneral Sarvice Licenses PO Box 58007 Washington DC 20037 en 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata fntarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final THE WUG WITH METASTICES disaasa or condition rasulting in daath) Examiner Completed by Physician/Medical Examiner The law requires that the deeth certificate be executed ig physician and as the bunal-transit Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Couse (Disaase or injury that initiated evants resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): US8 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? OCCAS 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2No 1 Tas 2 No or Attanding Physician: funeral director, Be 25. Was casa refarred to medical axaminar? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mannar of Death 28a. Data of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Panding invastigation 24 hours after deeth. 1 Yes 2 No 2 Accident the 6 Could not be datamined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

213 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Division of Vital Records,

Box 68760.

P.O.

21215-0020

Baltlmore, Maryland

To the Hos within 24 h To the Fun completely

State Registrar 29b. Signatura and titla of certifiar

29c. License number D-18545

29d. Data signad (Month, Day, Year)

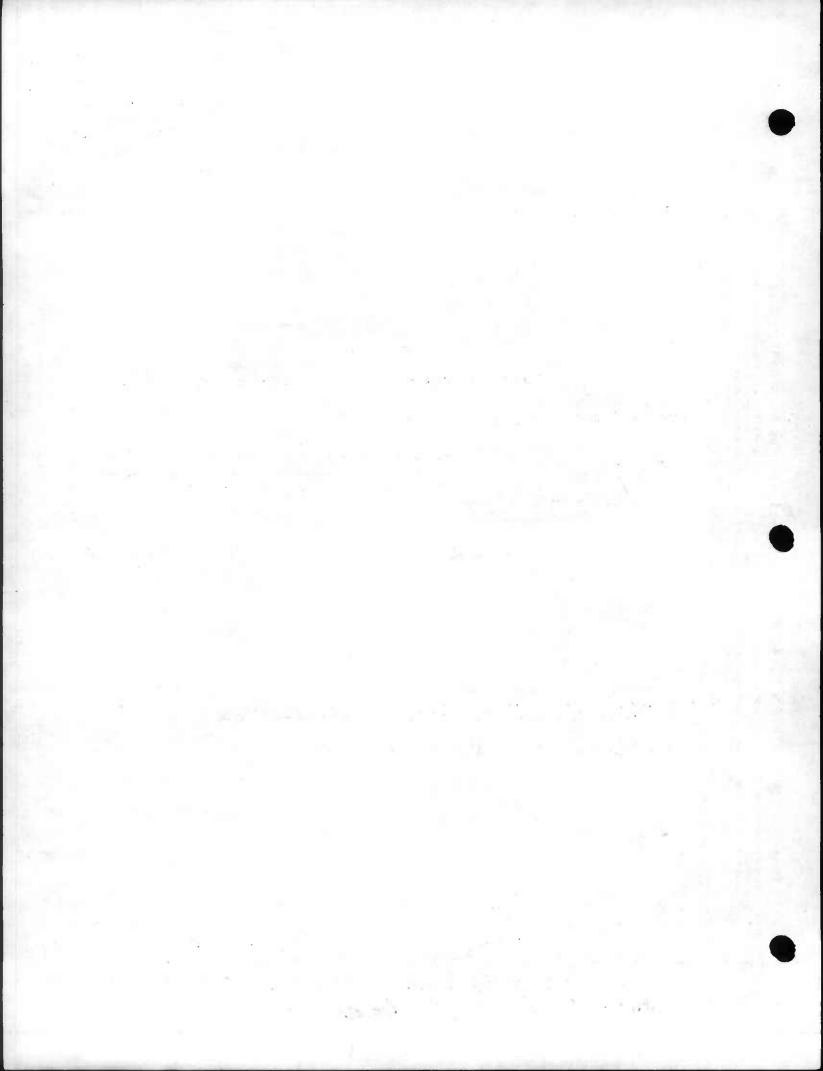
APUL 16, 1999

0. Nama and addrass of person who complated cause of death (ftern 23a) (Type, Print)

Maldor F, Maryland Zouc

Old Line Center Suite 207
Magth, Day Years

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev STEVEN Y. BROWN 04 80 99 5:15PM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Waldrof if Under 24 Hrs. Charles 3820 Light Arms Place If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Min. M 20 F Months Deys Hours June 24, 1924 Washington, DC 579-24-8762 Usual Rasidance of Deceden 74 10d. Inside City Limits 10b. County 10c. City, Town or Location 17 Yes 2 No Waldrof Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20602 USA 3820 Light Arms Place 12. Wes Decedent Ever in U,S. Armed Forces? 17 Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced USYOCOAST Guard 16a. Dacedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) 12th Postal Worker US Postal Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Brown Susie Moore Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice L. Brown/wife 20602 3820 Light Arm Place Waldrof, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cematary, crematory or other place) Dete 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ington National 4/14/99 Suitland, MD 22. Name and Address of Facility LATNEY'S FUNERAL HOME, INC Washington National 21. Signeture of Funeral Service Licenses 3831 Georgia Ave., NW 20011 Wash.,DC 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Intarval Between Onsat end Deeth Immadiata Causa (Final disease or condition rasulting in death) PROSTATE CANCER Dua to (or as a consaquance of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaasa or injury Dua to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

Š

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mentel Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinar must be notified at

Examine The law requires that the death certificate be executed physician and s the buriel-transit Physician/Medical ettending ph for use es t by the e signed b à been signal Completed

P.O. Box 68760.

certificate hes l or Attending Physician: this funeral After deeth. octor:

Be

To

Certification:

edical

Division of Vital Records. Direc 24 hours efter Funeral Dire letely filled in b Hospital To the Hosp within 24 ho To the Fune completely fi

Registrar

0 State

28a. Date of Injury (Month, Day Year)

1 Yes 2 No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and dua to tha cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

26. Placa of Daath (Check only ona)

Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

28d. Dascribe how injury occurred

29d. Date signed (Mogth, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who complated ceuse of death (Item 23a) (Type, Print) 0

Hospital:

5 Panding investigation

6 ☐ Could not be

31. Date filed (Month, Day, Year)
APR 1 3 1999

25. Was cese referred to medicel axaminar?

1 Yes ZINo

27. Mannar of Death

2 Accidant

3 Suicide

29a. Certifier

4 Homicida

(Check only one)

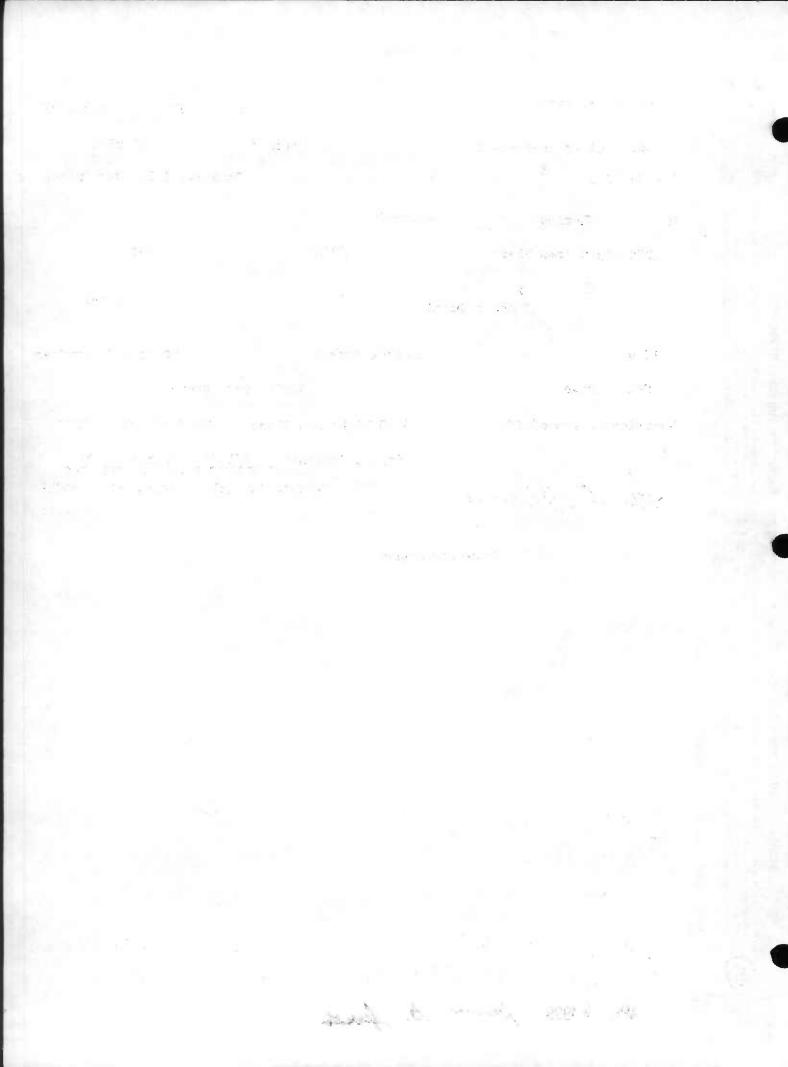
29b. Signeture and title of certifier

32 Registrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		Certifica	te of L	Death		Reg. No.		
Decedent's Name (First, Middle, Last)					2. Dete of De Month	eth Dey	Yeer	3. Time of Deeth
LESLIE LLOYD BLAG					APRIL	10,1	1999	lu: 15Am
4e Fecility Neme (If not institution, give s	7.54				or Location of Deeth	4c. Count	y of Death	
WASHINGTON ADVENT 5. Sociel Security Number 6. Sex		et hirthaby) If Unde	T Year	AKOMA I		MONTO	GOMERY	an (State of Fernier
578-50-9994	M 2□F 59	Yrs. Months			fin. 8. Dete of Bir (Month, De MAY 22,	y, Year) 1939	Countr WASH	ce (Stete or Foreign X) INGTON DC
Usuel Residence of Decedent					, , , , , , , , , , , , , , , , , , , ,	1737	WADII	INGTON DC
10a. Stete 10b. County	10c. City,	Town or Location					100	d. Inside City Limits
MD PRINCE GE	ORGES DIS	TRICT HEIG	THTS					1 X Yes 2 □ No
10e. Street and Number			ip Code			10g. Citizen of	Whet Countr	y?
1802 GLENDORA DR.		20	747			UNITE	STAT	ES
11. Merital Stetus	2. Was Decedent Ever in U,S Armed Forces?	. 13. Wes Dec	edent of Hi	ispanic Origin	(Specify Yes or No uerto Rican, etc.)	- 14. Ra	ce - America	n Indien,
1 ☐ Never Married 2 Married	1 ☐ Yes 2 🕅 No		2 No		20110 1 110451, 010.)			
3 Widowed 4 Divorced	Yeer or Dates:	10,00	-20110	opouny.		Spacin	y: BLACE	(
15. Decedent's Educ (Specify only highest grede		16e. Decedent's Use (Give kind of w life. DO NOT	ual Occupa ork done d	ation during most of	working	16b. Kind of B	Business/Indu	stry
Elementery/Secondery (0-12)	College (1-4or 5+)			"				
11. Fether's Neme (First, Middle, Last)		BOOK BIN	DEK	18 Mother's	Name (First, Middle,		RNMENT	
LEO BLAGBURN								
19e. Informent's Name/Reletionship (Typ	ne Print)	19h Mailine Add-	es (Stroot -		CE McCALL Rural Route Number		State 7in f	(ade)
LESLIE L. BLAGBUI								,000
20e. Method of Disposition	20b. Ple	ece of Disposition (Ne	eme of		. WASHING	20c. Location		n, Stete
1 ☑ Burial 2 ☐ Cremetion 3 ☐ Re	emovel from Stete	metery, cremetory or	other plea					
4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service License		ORT LINCOL		METERY ss of Fecility	4-15-99	BRENTW	MI, door)
J. Signotale Sir Uniolal Service License	1	ALEX	ANDER	R S. PO	PE FUNERA	L HOME		
Neith a 1 &	20x M/08-	5 5538	MARLE	BORO PI	KE , FORE	STVILLE	E,MD 20	747
23a. Pen1. Enter the disease, or complic shock, or heart feilure. List only one	e ceuse on eech line.	Do not enter the mo	ae or ayını	g, such es car	diac or respiretory e	rrest,		Approximete ntervel Between Onset and Deeth
Immediate Cause (Final	C 14						1	, A
disease or condition resulting in death) e.	Sept	ecomo						Days
	1/0	es e consequence of	n): . /	- 1-				
b.	Urman	met	my	eeun	und		On	e Week
Sequentially list conditions, if eny, leading to immediate cause. Enter UnderlyIng	Due to (gr	s e consequenca of	1.1	- 1			0	, 1.11-
that initiated events	Due to for	es e consequence of	~ W	, me	4		Ser	real week
resulting in deeth) Lest	Coment	The A		ue Fa	line		64	Known
d.	30	me con	all	u fat				
Part II. Other eignificent conditions cont	ributing to death but hot result	ting in the underlying	cause give	en in Pert I.	23b. Did	tobecco use co	ontribute to t	the cause of death?
John Marie Control of the Control of	and the state of t	. a aaonymy	Janua yire			Yes 2□ No		. /
					-			
					24a. Was	en eutopsy	24b. Wer	e eutopsy findings leble prior to
				1	_ penc		com	pletion of cause eeth?
					10	res 2 No	10	Yes 2□ No
25. Was case referred to medical	/			26. Plece of	Death (Check only of			
23. Was case referred to medical	ospital: 1 Impatient 2 E	R/Outpetient 3 D	OOA Othe	or	g Home 5 Resi		ther (Specify)	
exeminer?		28b. Time of	28c. Injury Work			how Injury occu		
exeminer? 1 Yes 2 No 27. Manney of Deeth	(Month Day Vess)	Injury M		Yes 2 □ No				
exeminer?	28e. Dete of Injury (Month, Dey Year)				28f Location /	Street and Num	ber or Rurel	Route Number,
exeminer? Yes 2 No	28e. Plece of Injury - At hon	ne, ferm, street, fecto	ory, offica		City of Tax	um State 1		
exeminer? 1 Yes 2 No 27. Manne of Deeth 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		ne, ferm, street, fecto	ory, offica		City or To	vn, State)		
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exeminer? 1 Yes 2 No 27. Manne of Deeth 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature end title of certifier	28e. Plece of Injury - At hon building, etc. (Specify) clan: To the best of my know er: On the basis of examination menner steted.	ledge, deeth occurre on end/or Investigatio	d et the timen, in my op	pinion, death o	City or Ton	ceuse(s) end m dete end plece 29d. Date sign	, end due to t ed (Month, D	he ceuse(s) ey, Year)

Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month/ Day 10/ Preston R. Booze 9:29 p.m. 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Prince Georges General Hospital Cheverly, MD Prince Georges If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Deys 1⊠M 2□ F Months Yrs. 6/29/1940 58 579-50-7756 Washington, DC Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Prince Georges Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4303 Riveria Court 20748 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 Never Married 2 Merrled 1 ☐ Yes 2 ☒ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private 10th 3 yrs apprentide Contractor/Painter 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Elsworth E. Pierce Thelma G. Booze-Skinner 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Rosetta Gentles Booze 4303 Riveria Court, Temple Hills, MD 20748 Piece of Disposition (Neme of piece) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 Cremation 3 Removal from Stete 4 Donetion 5 Other (Specify) 4/16/99 Clinton, MD Forest Hills Memorial 21. Signature of Foneral Service License 22. Name end Address of Fecility wund Dudley Funeral Home Edward M. Dudley 3200 Rhode Island Ave., Mt. Rainier, MD 20712 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final ENSION disease or condition resulting in deeth) Abus Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initieted events resulting in deeth) Last Due to (or es e consequence of) Due to (or es e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 Yee 2 Al 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐-Nб 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one)

physician and the burial-transit the daath certificate be axecuted 88 esn ò signed by the a

Records, P.O. Box 68760.

Division of Vital Attending Physician:

ò Hospital

Physician /Medical

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Examiner

Physician/Medical

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Completed

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Certification: To

Medicai

29b. Signeture end title of certifier

APR 1 8 1999

Physician

/Medical

Examiner

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Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mentel Hygiena. Important if Itam 27 is marked other than "natural; or itema 23a or 28a-f show any injury or other traumatic event, the Medical Example: must be notified once.

Baltimore, Maryland 21215-0020

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after deatl 24 hours after Funeral Directors letely filled in b

To the Hosp within 24 hor To the Fune completely fi

State Registrar 25. Wes cese referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA 28e. Dete of Injury (Month, Day Year) 28c. injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Maturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end manner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

CHEVERLY,

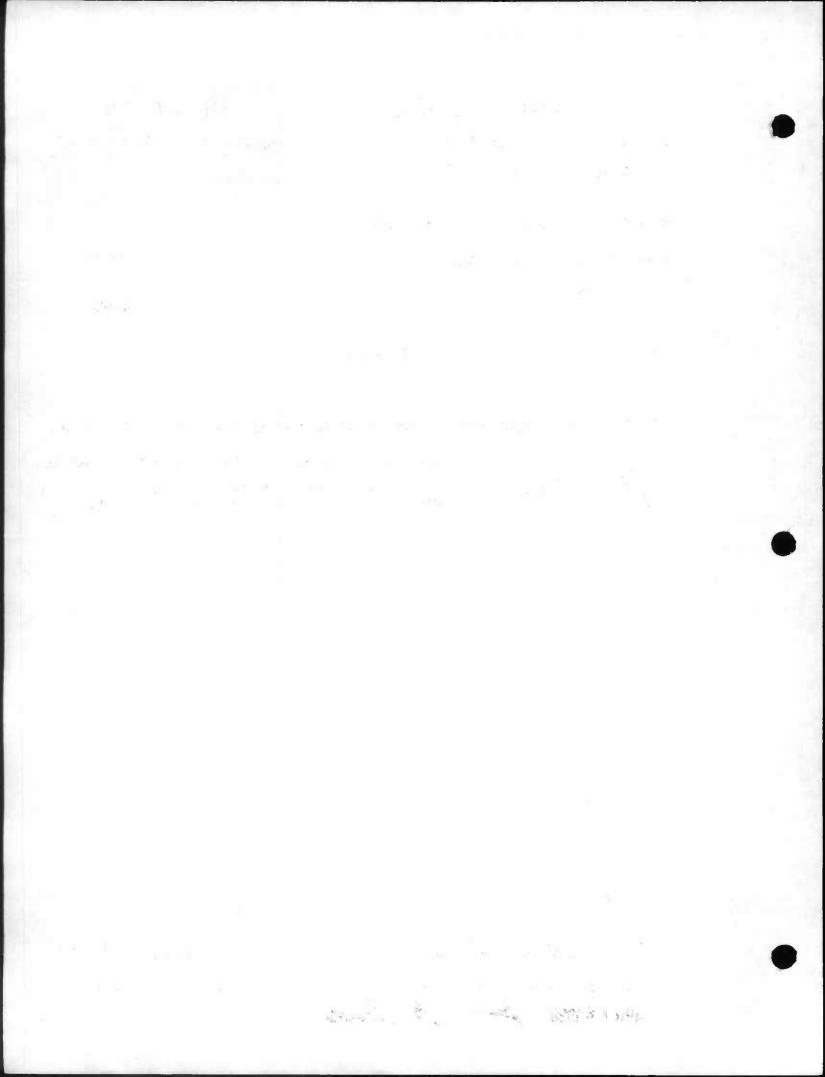
30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)

3001 wistopher HOSPIPA (32. Registrer's Signature 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

					iaryiano i	Certific		Death	iviei		giene Reg. No.)
	Physic /Medi		1. Decedant's Name (First, Middle, Li	eth	Bar	Hle			2.	Date of De	Day	99	3. Tim	of Death
	Examir Funeral Director			er-Ger	VISIS ga (In yrs. last	birthday) If Ur Yrs. Mont	ndar 1 Yaar) { [\lambda \text{V} S. 8]	1.1) m	ontag	aca (Ste	eta orforaign
	dand ww		Usual Residence of Decedent 10a. Stete 10b. County		10c. City, T	own or Location						11	Od. Insid	le City Limits
	with the Maryland a or 28a-f show be notified at	ctor	MARYLAND MONTGO	MERY	ROC	KVILLE							1 🗆	Yas 2X No
	with th	Director	10e. Street and Number			10f.	Zip Coda				10g. Citizen of		•	
020	72 hours after death with the Maryland natural', or items 23a or 28s-f show great Examinet must be notified at	by Funeral	5901 MONTROSE R 11. Marital Status 1 Naver Married 3 Widowed 4 Divorced	OAD APT S 12. Was Dacedant Armed Forces 1 Yes 2 If Yes, Giva Yaar or Dates:	Evar in U,S.		208 secedent of hispecify Cub	lispanic Origin? (an, Mexican, Pue	Specifi rto Ric	y Yas or No an, etc.)	UNITED 14. Rai Bie Specifi	ce - America ck, Whita, o	an India etc.	٦,
Maryland 21215-0020	c .	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation eda complated) College (1-4or			f work dona T use retire	pation during most of wo d)	orking		16b. Kind of B	usiness/ind		
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ylar	0 5 0 0	To E	DANIEL SMITH					ISABEL	LE	SMALL	WOOD			
Mar	0555		JOSEPH BATTLE		17)	19b. Mailing Add	ress (Street	and Number or F	Rurel A	loute Numbe	er, City or Town	, State, Zip 2(Code) 0852	
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Division	To the Hospital or Attending Phi within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	1 Netural 5 Pending Investigation 3 Sulcide 4 Homicide	28e. Piace of In		injury M , farm, street, fac	10	Yes 2 □ No	281	Location (S City or Tox	Street end Num vn, Stete)	ber or Rura	l Route	Vum <i>ber</i> ,
	n 24 hours n 24 hours e Funeral	edicai C		nyalcian: To the best niner: On the bests of and manner st	of examination									se(s)
	To th Withir To th comp	Me	29b. Signature end title of cartifier		00-		29c. Licans				29d. Date signe	ed (Month, i	Day, Ye	ar)
	(3)		30. Name and addrass of person who	completed cause of	death (Item 23	a) (Type, Print)	DB	8262	_		April	7,1	99	9
(9		Dr Mendhir	alta, 1	81111	Prince	2 Phi	lip Dr	8u	rles	202 Olk	eyM	10	2580
	Sta		31. Date filed (Month, Day, Year)	37. Regist	rar's Signature	4 6	a it	/						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month **Physician** 1999 12:25 AM Elinor J. Breen April 9, /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner ANNAPOLTS AT Months Davs Hours Min. (Month, Day, Year) ANNE ARUNDEL HOSPITAL ANNE ARUNDEL Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕏 F Months Yrs. 67 Director 218-30-2698 MAY-21-1931 MARYLAND Usual Residence of Decedent the Maryland 10e State 10h Counts 10c. City. Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan and Mentel Hygiene.

The file of the state of the Mentel Hygiene.

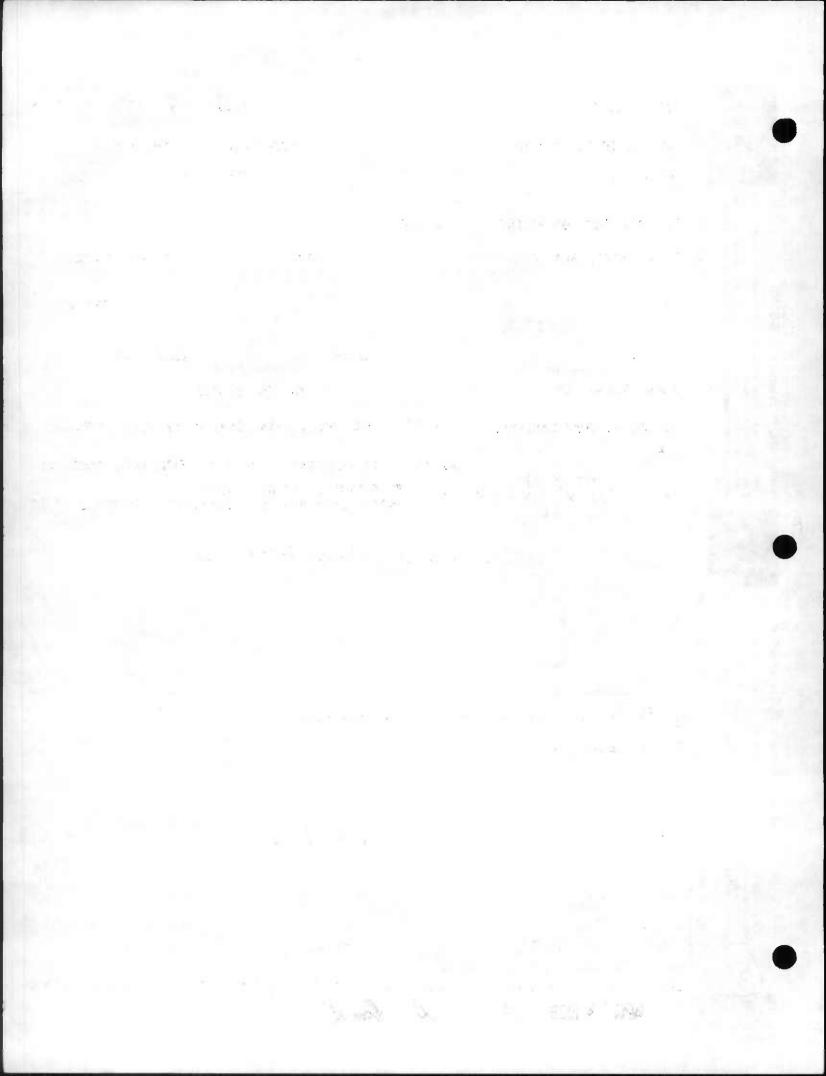
The file of the state of the file of the stat 1 ☐ Yes 2 H No Directo MARYLAND ANNE ARUNDEL **JESSUP** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7810 CLARK ROAD, A-46 20794 UNITED STATES Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Merital Status Black, White, etc. 1 □ Never Merried 2 □ Merried Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à 3 Widowed 4 Divorcad WHITE Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 CLERK DRUG STORE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be 10 MELVIN FLORA, SR. BLANCHE TALBOT 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 7810 CLARK ROAD, A-46, JESSUP, MARYLAND 20794 JOLENE M. GOAD-DAUGHTER Baltimore, 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, crematory or other piece) Dete 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State Department o Important: If any injury or ance. 4 ☐ Donetion 5 ☐ Other (Specify) 4-14-99 BRENTWOOD, MARYLAND FORT LINCOLN CEMETERY 21. Signature of Funeral/Service Ligensed 22. Name end Address of Fecility FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximate Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final Accupante diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that leated events.) Due to (or es e consequença of) death certificate be execu Box 68760 Physician/Medicai that Initiated events resulting in deeth) Lest Due to (or es e consequence of) 98 BSI ò ed by the a Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown sevene THEILHATOLD ANTARITIS signed be det Records. by 24b. Were eutopsy findings eveilable prior to Completed 24e. Wes en autopsy completion of cause of deeth? pege 2 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerel 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: After 1 Matural 5 Pending efter death. Director: Aft 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a, Certifier edicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of cartifier Zun D13687 4-11-00 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) D. MACONE MISS PARENTE SIGNETURE PARENTE PAREN 1 Roby Lue Belsulle MD 2005 JOSENTO State

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Registrar



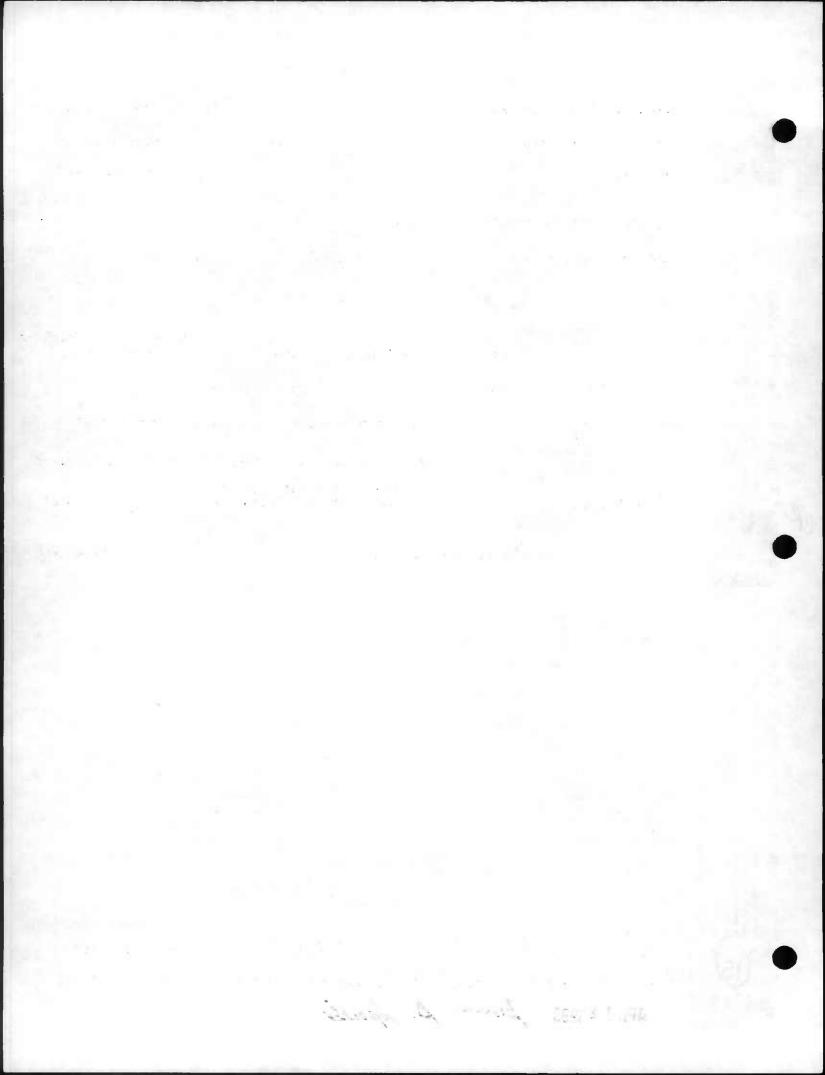
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	Examine		4a Facility Name (If not institution, giv		nber)			4			cation of Deat			
Ĺ			2606 Muskogee St				If Under 1	Voor	Ade	elph:				eorge's
	Funeral Director		219-26-8864	ox □M 2ŽŠF	7. Age (in yrs. 61			Days	Hours	Min.	8. Date of Bir (Month, Da Nov. 23			place (State or Foreign ntry) ryland
	2 should be filed within 72 hours after death with the Maryland end Mental Hygiene. Is marked other than "natural", or items 23s or 28s-4 show aumatic event, the Medical Examinal must be notified at The Bell Completed by European Placeton.		Usual Residence of Decadent 10a. State 10b. County Maryland Prince	George':		y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with the		10e. Street and Number				10f. Zip (10g. Citizen of		ntry?
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020	al', or item Examiner	DA LO	1 Never Married 2 Married 3 X Widowed 4 Divorcad	Armed For 1 Yes If Yes, Give Year or Da	ces? 2 No e		If Yes, specif			, Puerto	ecify Yes or No Rican, etc.)	Specify Specify	ck, White,	
5-0	72 ho	100	15. Decedent's Ed (Specify only highest gre	lucation de completed)		16a. Deced	dent's Usual	Occupa done	ation	of work	ina	16b. Kind of B		
Maryland 21215-0020	be filed within 72 hor tal Hygiene. d other than "natura event, the Medical E	duo	Elementary/Secondary (0-12)	College (1-	-4or 5+)		kind of work DO NOT use .stant					Univers School	-	of Maryland ursing
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yla	should be in and Mental I in marked of urmatic eve	2	Patrick Henry	William	S				Ruth	n R	ichter			
Jar			19a. Informant's Name/Relationship (er, City or Town		
	1 end Health sm 27 ther tr		Gordon Brooks - S	on	DOL D	601 C			Lane	, Pi		ton, Oh		43147
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Balti	permit. Pages 1 e Depertment of Hes important: if item any injury or othe phes.		21. Signature of Funeral Service Licar	- 1	Α .	n Ga	Name and	Addres	s of Facilit	Home	e, P.A.			
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	y fill		29a. Certifier 1 Cartifying Ph (Check only one) 2 Medical Exam	ysiclan: To the la niner: On the ba and mann	sis of examinat	wledge, death tion and/or inv	n occurred at vestigation, i	t the tim	ne, date en pinion, deat	d place, a	and due to the ed at the time,	cause(s) end m date and placa,	enner as s and due t	stated. to the cause(s)
	To the Ho within 24 I to the Fu completed		29b. Signature and title of cartifier	1) 1	11.		29c.	License	number			29d. Date signe	d (Month,	, Day, Year)
	(15)		> Thicholas W	Koule	hille	CIM		D3	390	5		April	12,	1999
	(13)	- 1	30. Neme and eddress of person who Nicholas W. Koutr					e Pa	atuxei	nt P	kwy, Co	lumbia,	MD	21044

Registrar

APR 1 2 1999





Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Death 2 Data of Death 945 AM Elizabeth 1979 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva streat and number) 4c. County of Death Regional aurel 1 to suite If Under 1 Year If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. Aug 22, 1940 5 Social Sacurity Number 7. Age (In vrs. last birthday) Birthplaca (State or Foraign Country) 1□ M 2X F Months Days 195-30-6303 58 Pennsylvania Usual Rasidence of Dacedani 10a Stata 10b County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No Prince George Laurel 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 8500 Portsmouth Drive 20708 USA 12. Was Dacadant Ever in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian. Black, Whita, atc. 1 Yas 2 No If Yas, Give Yaar or Datas: 1 ☐ Naver Marriad 2 M Married 1 ☐ Yas 2 No Specify: Specif White 3 Widowed 4 Divorced 16a. Dacadent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highest grada complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) years Referral Coordinator Doctor's Office 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Father's Nama (First, Middla, Last) Albert Finch Jeannie Emick 19a. Informant's Nama/Ralationship (Typa, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) James M. Cook, Sr. /husband 8500 Portsmouth Drive, Laurel, Maryland 20708 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1X Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) 4/16/99 Crownsville, Maryland Maryland Veterans Cem. 21. Signature of Funeral Service Licen. 22. Name and Addrass of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 25a. Part. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart policy. List only one cause on each line. Approximata Intarvel Betwean Onsat and Daath Immediata Causa (Final disaasa or condition rasulting in death) Sentic shock throusophle b. fi, Laft Jusc la Dua to (or as a consequence of): Monte paratrol feeling 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown a renen hy refer to of 24a. Was an autopsy performed? 24b. Wara eutopsy findings available prior to preuntora completion of cause of death? Coques rol 26. Plece of Death (Chack only ona)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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7 is merked other than "natural", or items 23s or traumetic event, the Medical Examiner must be

parmit. Pages 1 end 2 should be filed within 72 hours efter Department of Heelth and Mentel Hygiona. Internation 17 is marked other than "natural, or its marked other than "natural," or its may nitury or other traumatic event, the Medical Engine.

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Division of Vital Records,

I or Attending P after deeth. Director: Aftar t

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Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I.

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Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify)

27. Mannar of Death Natural 5 Panding Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b. Tima of

28d. Describe how injury occurred 28c. Injury et Work?

invastigation 2 Accident 6 Could not be determined 3 Suicida 4 Homicide

28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

28f. Location (Street end Number or Rural Routa Number, City or Town, Steta)

29a. Cartifiar (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated. Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar stated.

2 Madical Examiner: On the basis of axamination end/or invastigation, in my opinion, daeth occurred et the time, date and place, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifiar

29c. Licansa number

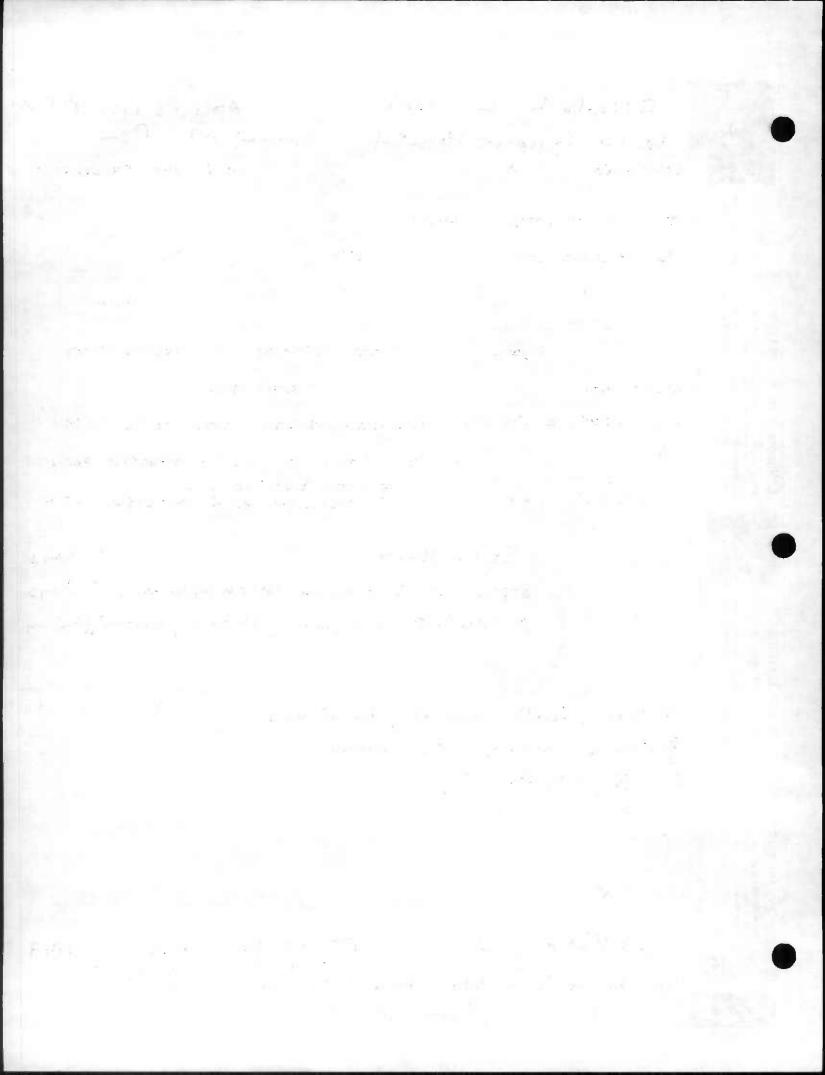
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29d. Data signed (Month, Day, Year)

30. Nama and address of person who complated causa of daath (Item 23e) (Type, Print) Park Low of Drwn Sk 214

Registrar

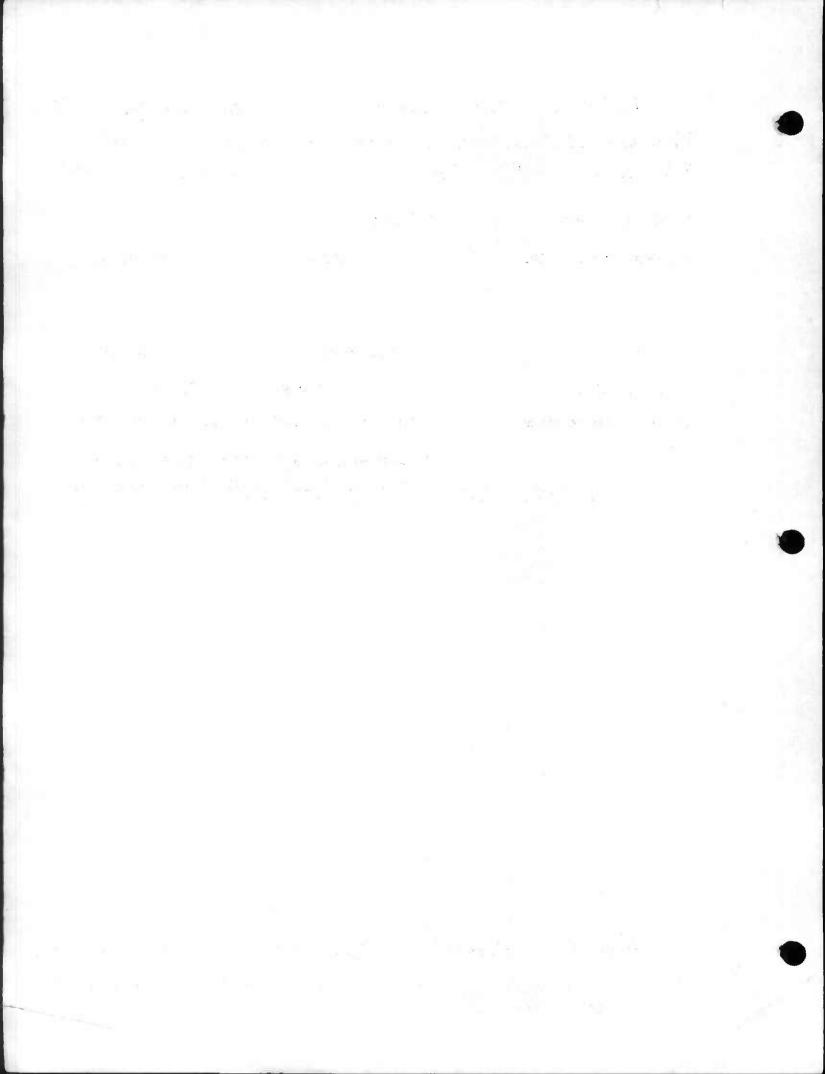
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State of Maryland / Department of Health and Mental Hygiene

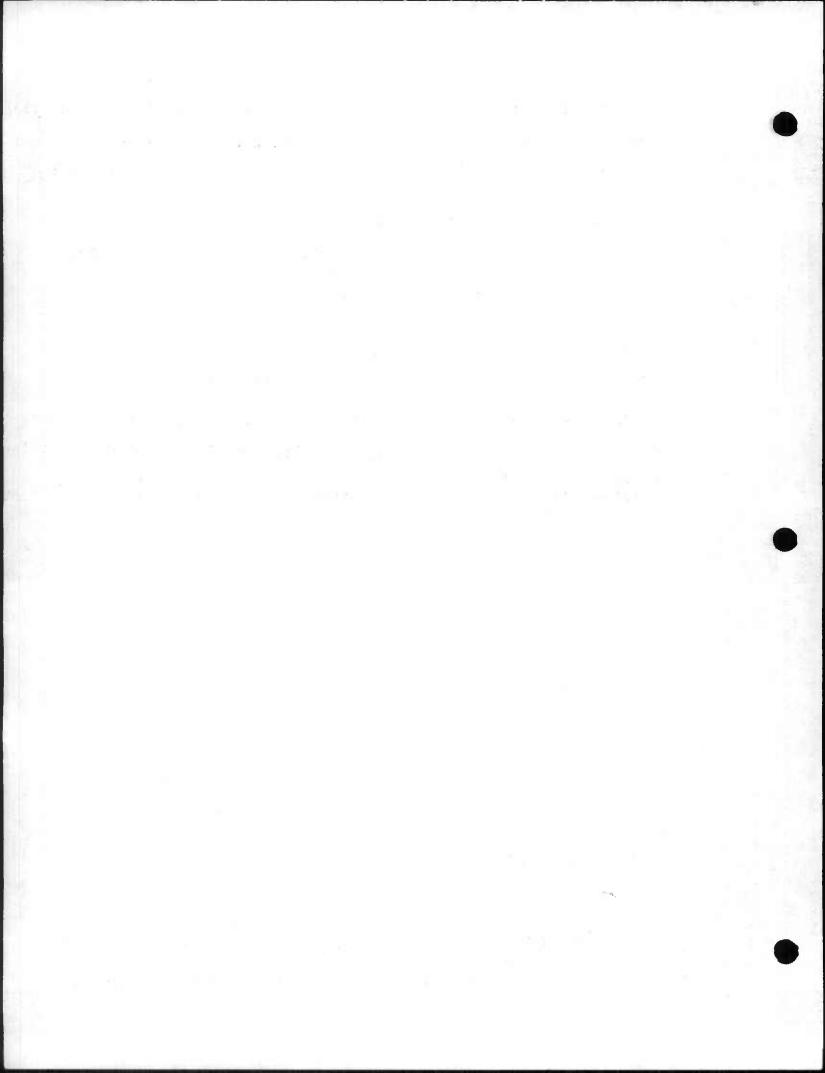
			State of Mil	-	Certificate of			eg. No.	14:125
	Physic /Medi		1. Decedent's Nama (First, Middle, Last) MARIE	ULL	um.		2. Dete of Deer Month	th Day	7.20
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	the Mary 28a-f sh	Director	Maryland None	Ва	ltimore				1 A Yas 2 No
ore, Maryland 21215-0020 s 1 end 2 should be filed within 72 hours effer deeth with the Maryland of Health end Mentel Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exercites must be nyttled at		by Funeral Dir	10e. Street and Numbar 905 West Franklin St. 11. Marital Status 1₺ Nevar Married 2□ Married 3□ Widowed 4□ Divorced 1□ Yes 2₺ Nif Yas, Giva	if Yas, specify Cuban, Mexican, F					,
21215-0020	within 72 house.	Completed	t5. Decedant's Education (Spacify only highest grade complated) Elamantary/Secondery (0-12) Collaga (1-4or 5		Dacedant's Usuai Occup (Give kind of work dona lifa. DO NOT use retired Housekeepe:	d)	orking	16b. Kind of Busi	nass/industry
	d be filed intel Hygie ad other	Be	17. Fathar's Name (First, Middla, Last)		nousereepe	18. Mothar's Na	ma (First, Middla, I	Maidan Sumame)	
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Baltin	permit. Pege Department of Important: If any Injury or once.		21. Signature of Funaral Sarvice Licensaa	7A 10	Shepherd Cer 22. Nama and Addra Harry H. W.	ss of Facility itzke's	Family Fu	neral H	t City, MD ome, Inc. ty, MD 21043
1	Physician /Medical Examiner	r.	23a. Part1. Enter tha diseese, or complications thet caused shock, or haart failura. List only ona cause on each lir Immediata Causa (Finai disease or condition rasulting in death)	ume	not enter the mode of dyir	ng, such as cerdia	c or raspiratory arr	ast,	Approximate Interval Between Onset and Deeth
68760,	thet the death certificate be executed ed by the ettending physician and detached for use es the buriel-transit	edical Examiner	if eny, leading to immadiate ceuse. Entar Undarlying Causa (Disaase or Injury	Dua to (or as a c	consequence of):	HROM	nBOSI!	S	
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Divisi	i or Attendi efter deeth. i Director: A d in by the f	Certification:	3 Suicide 6 Could not be		rm, street, fectory, office		28f. Location (St City or Town	treet end Number n, Stata)	or Rural Routa Number,
	To the Hospital within 24 hours of To the Funeral Completely filled	edical (29a. Certifier (Check only one) Certifying Phyalclan: To the best of end mannar sta	axamination and	, daath occurred at the tin d/or invastigation, in my o	na, data and place pinion, daath occi	e, and dua to tha courred at tha tima, d	ausa(s) and manr ata and place, an	ner as statad. d dua to tha cause(s)
	To the Comment	Σ	29b. Signatura end titla of certifier Mardobazeev	no	29c. Licans	a number	2	9d. Data signed ((Month, Day, Year) - 4 - 999
	2		30. Name end eddrass of parson who completed cause of de	F 8	Type, Print)	H FW	AW ST	BALTI	MORE MD.
Ī	Sta Registr		31. Data filed (Month, Day, Year) 6 1999 32. Ragistra	s Signatura	/ /	ude)			



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Certificate	e of Death	F	leg. No.	F V 304
1. Decedent's Name (First, Middla, La	ast)			2. Dete of Dee	th	3. Tima of Deeth
Physician Walter Fred Cr	ouse			April	Day Y	⁵ 10 PM
/Medical Examiner Wallel Filed CI 4e. Fecility Neme (If not institution, gif			4b. City, Town, o	or Location of Deeth	4c. County of	
8610 Mackall	Road		St. Leon	ard	Calv	ert
	Sex 7. Aga (In yrs. las	t birthday) If Undar	1 Yeer If Undar 24 H	rs. 8. Deta of Birth	9	Birthplace (Stete or Foreign
Director 225 22 3183	¥2 M 2□F 77	Yrs. Months	Days Hours M	April	1 1922	Virginia
Usuai Rasidance of Dacadent						
10a. Stata 10b. County	10c. City, 7	Town or Location				10d. Insida City Limits
Maryland Calve	rt St.	Leonard				1 ☐ Yes 2 ☐ No
Maryland Calve		10f. Zip	Coda] .	log. Citizan of Wh	at Country?
8610 Mackall	Road		20685		United	States
11. Marital Stetus 1 Nevar Married 2 Married	12. Wes Decedent Ever in U.S.				-	Amarican Indian,
D = 1	Armed Forcas? 1 ☐ Yas 2 ☐ No	If Yes, speci	ant of Hispanic Origin? ify Cuban, Maxican, Pu	arto Rican, etc.)	Black,	Whita, atc.
10a. Stata 10b. County Maryland Calve Maryland Calve Maryland Calve Maryland Calve Maryland Calve Maryland Calve Maryland Calve 10e. Street and Number 8610 Mackall 11. Marital Stetus 1 Decedant's E (Specify only highast gr Elamantary/Secondary (0-12) 7th 17. Father's Name (First, Middle, Las George Crous	If Yas, Giva A Yaar or Datas:	1□Yes 2	No Specify:		Specify W	hite
15. Decedant's E	Education	16a. Decedent's Usua	Occupetion	1	16b. Kind of Busin	nass/Industry
T5. Decedent's E (Specify only highast gr	rada complated)	(Give kind of work life. DO NOT us	k dona during most of v	vorking		•
Clamantary/Secondary (0-12)	Collega (1-4or 5+)	herdsman			Cattle	Farm
T Father's Name (First, Middle, Las		nerusman	18. Mother's N	ame (First, Middla,	Maidan Sumeme)	
Day The state of t	е		Elli	e Hale		
George Crous George Crous 19a. Informant's Neme/Raiationship	(Type Print)	10h Mailing Address	(Street and Number or	Rural Rouda Mumba	r City or Town St	ete Zin Code)
19a. Informant's Neme/Raiationship. Della Crouse-						0111 1111 111
Della Crouse- 20a. Mathod of Disposition	20h Plac	e of Dienoelston (Alam	o of	Data	con tonnellan Ci	yland 20685
2 2 2 2 2	□Ramoval from Stata cam	etery, crametory or of	har plece) April	23 199	9St. Le	onard Maryla
1 Donation 5 Other (Speci				rery		
21. Signature of Funeral Sarvice Lica	insee	22. Nama end	Address of Facility R	ausch F	uneral	Home PA
- Droue	son	4405 B	roomes Is	. Rd. P	ort Rep	ublic MD 206
23a. Part1. Entar tha disaasa, or con shock, or haert failura. List only	nplications that caused tha daath.	Do not entar tha mode	of dying, such es card	iac or respiretory ar	ast,	Approximata Intarval Between
Physician	_					Onsat and Deeth
/Medical Immediate Causa (Final disaasa or condition	RECOIRA	DRY	FAILURE			hull
Examiner resulting in death)	Dua to (or e	s a consequence of):	111001100	W		
n z c	. END STAC	E CHRO	MIC DB	1. PuL.	DICCHI	3-5 un
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Cause. Enter Underlying Cause (Disaese or injury that initiated avants rasulting in daath) Lest	c Due to (or as	s a consequenca of):				
9 FE Tasulting In death) Lest	,	,				
	d					i
Pert It. Other aignificant conditions	contributing to death but not resulting	no in the underlying ce	uses given in Part i	23h Did t	nhecco use contr	ibute to the cause of death?
Day of the dear the d	contributing to death out not result	ng in the underlying ce	iosa given in ranti.	100		Probably 4 Unknown
S. Ses that D. Dy P. De det				_ ''^	98 2L 140 3	- Trobably 4 Donklown
				24a. Was a	an autopsy	24b. Were eutopsy findings
S sport				perfor	med?	evallable prior to completion of cause
The lew requirements the lew requirements have been a page 2 should Completed						of death?
				1 🗆 Y	as 2 No	1 ☐ Yas 2 ☐ No
25. Was casa raferred to medical axaminar? 1	Hospitai:		Other	eeth (Check only or		
1 Yas 2 No	1 Inpatiant 2 I EF	VOutpatient 3□ DO.		Homa 5 Resid		
O L Specification investigation	28a. Data of Injury (Month, Day Year)		Bc. Injury at Work?	28d. Dascribe h	ow injury occurred	1
O to to to to to to to to to to to to to		М	1 ☐ Yes 2 ☐ No			
27. Mannar of Death Second Particular Particular		a, farm, straat, factory,	office	28f. Location (S City or Tow		or Rural Route Number,
Hongical Paraminar. 25. Was casa raferred to medical axaminar? 26. Was casa raferred to medical axaminar? 27. Mannar of Death 28. Mannar of Death 29. Mannar of Death 29. Mannar of Death 29. Mannar of Death 29. Mannar of Death 29. Mannar of Death 29. Mannar of Death 29. Mannar of Death 29. Certifying Picketonly one) 29. Certifying Picketonly one)	hysician: To the best of my knowle miner: On the basis of axamination	edga, death occurred e	t tha tima, data and pla	ca, and dua to tha	ausa(s) and mann	nar as stated.
2520 0	and mannar stetad.	. Onwor investigation,	army opinion, death oc	ourou at tha tima, t	rata ana piasa, ani	מ מממ נה (נום הפהפם(2)
29b. Signatura and titla of certifier	A		Licansa number	_	29d. Data signed (
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	am not		05024	9	April	20, 1999
30. Nama and address of person who	completed causa of daath (Itam 23	3a) (Type, Print)				20679
	1 M D 110 U	ospital I	Rd. Suite	303 Pr:	ince FR	ederickMD
g Pranay R. Pate	I, M.D. 110 M	oppredi i	THE DULL			CUCLICKIID



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month DELLA L. CHANDLER April 9, 1999 11:00AM 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Mariner of So. Maryland 9211 Steuart Ln. Clinton, MD Prince Georges Hours Min. 8. Data of Birth (Month, Day, Year) 02-24-24 7. Aga (In yrs. last birthday) If Under 1 Year 5. Social Sacurity Number 6. Sax Birthplace (State or Foreign Country) Months Days 1 M 25 F 75 Washington, DC 149-26-7900 Usual Rasidance of Decedan 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No District of Columbia Washington, DC 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4040 8th St., NW 20011 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, Whita, etc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐ No Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Housewife Private 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Unknown Elazabeth Frazier 19a. tntormant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Davis Chandler/husband 4040 8th St., NW Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 17 Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 4/14/99 Glenwood Cemetery Wash. LATNEY'S FUNERAL HOME 21. Signatura of Funaral Sarvice Licensee 22. Nama and Address of Facility 3831 Georgia Ave., NW 20011 Wash., DC Lan Approximate Interval Between Onset and Death 23a. Part1. Entar the disease, or complications that daused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailura. List only one cause on each line. immediata Causa (Final ENDSTAGE RENAL FAILURE disaasa or condition resulting in death) Dua to (or as a consequence of): CARDIOMEGALY Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): DEMENTAL Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Whiknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, Stata

Funeral

Director

a or 28a-f ahow I be notified at

Items 23a

pernit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health end Mental Hygiene. Important: if item 27 is marked other than 'natural', or her may injury or other traumatic event, the Mexical Examine page.

Baltimore, Maryland 21215-0020

Director

Funeral

by

Be

2

Examiner

physician and s the burial-trensit that the death certificate be axecuted s been signed by the hes e 2 this Athar death.

P.O. Records, Division of Vital Attending after death after death Director: / d in by the f a Funeral Di detely filled in

Physician/Medical p Completed Be To Certification:

To the 2 Within 2 To the 3 State Registrar

68760 Box Medicai

29b. Signatura and titla of certifian

29c. License number DE 25640

28c. Injury at Work?

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

April 13, 1999

Location (Street and Number or Rural Route Number, City or Town, State)

- m 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

Davachi D. Khosrow Μ.

5 Panding invastigation

6 Could not be determined

1328 Southern Ave., SE Ste #303 Wash., DC 20020

26. Place of Death (Check only one)

Other: 4 Wursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

31. Data filed (Month, Day, Year)
APR 1 3 1999

25. Was casa ratarred to medicat axaminar?

1 Yes 2 No

27. Mannar of Death

1 XNatural

2 Accident

3 Suicide

29a. Certifian (Check only one)

4 Homicide

32. Registrar's Signatura

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

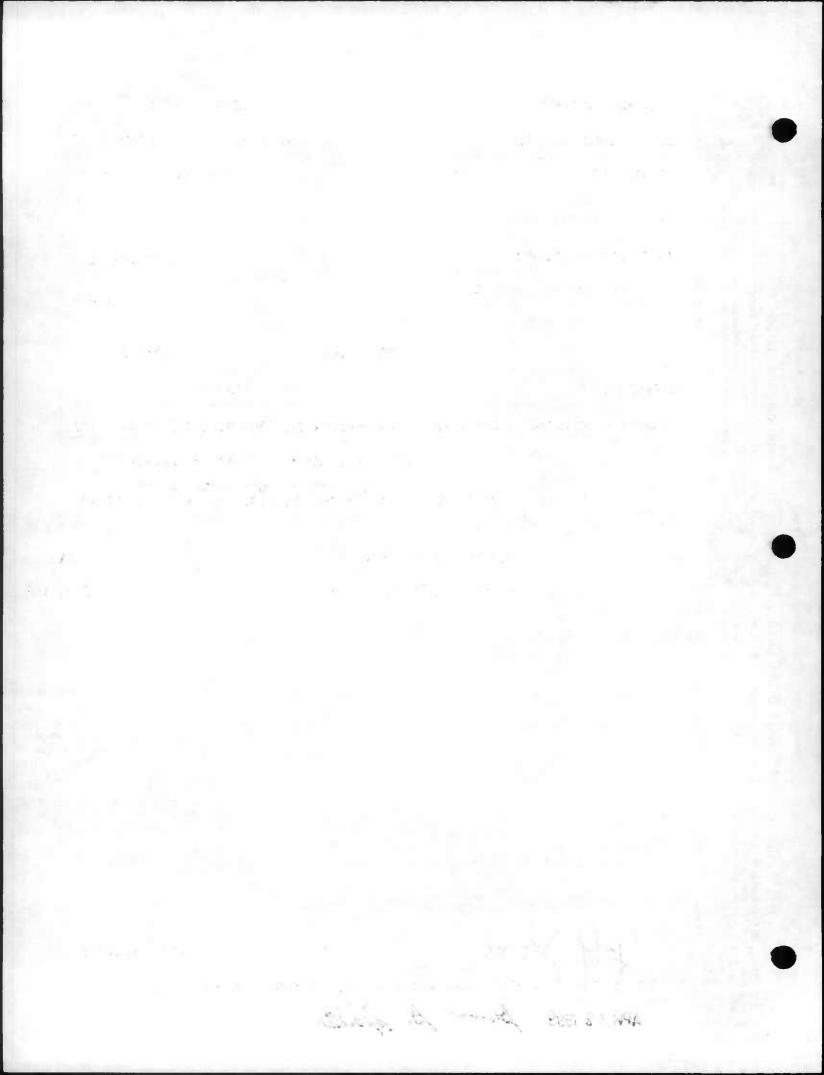
Place of Injury - At homa, tarm, street, factory, office building, etc. (Specify)

28a. Data of Injury (Month, Day Year)

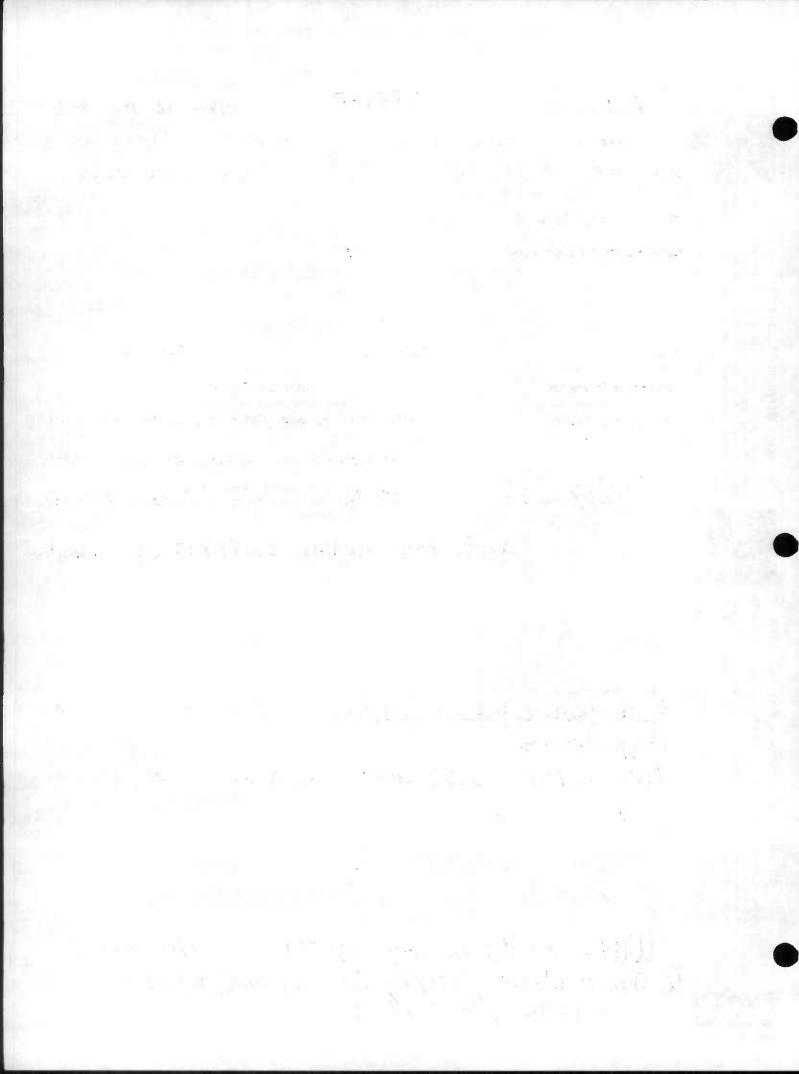


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hysician	IDA I	LEE CRAWI	FORD						APRIL	9,1 ^{Day}	Yeer	3:00am
/Medical xaminer	4e Fecility Nem	e (If not institution	n, give street er	nd number)			4	4b. City, Town, o	r Location of Dec		nty of Dee	th
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neral ector	5. Social Securit		6. Sex 1 □ M 2 X	7. Age (Ir	yrs. lest birthda Yrs.	y) If Under 1 Months	Year Deys	If Under 24 Hr Hours Mir	8. Date of E (Month, I SEPT.	lirth Dey, Yeer) 18,1932	9. Bird Co VI	thplece (Stete or Fore buntry) RGINIA
	Usuel Residence	a of Decedent 10b. County		10	c. City, Town or	Location						10d. Inside City Lim
10	A - B / 1/1		CE GEOR		HYATTSV:							1 XYes 2 □
rect	10e. Street end		OL OLOIC	OLID	IIIIIII IOV.	10f. Zip C	Code			10g. Citizen	of Whet Co	puntry?
from 234 of 284 and the notified Funeral Director	1509 M	ADISON S	ST. #30	2				782				
Jera	11. Maritel Stetu		12. Wes	Decedent Ever	r in U,S. 13	3. Was Deceder		lispenic Origin? (en, Mexican, Pue	Specify Yes or h	UNITEI	Race - Ame	erican Indian,
0 = _	3 ☐ Widowe	larrled 2□XMarr d 4□Divorced	rled 1 🗆	ed Forces? Yes 2 X No is, Give r or Detes;		1 Yes, specify		Specify:	nto Rican, etc.)	Spe	Bleck, Whit	BLACK
te pa	16	15. Deceden	it's Education	ntod)	16e. Dec	cedent's Usuel	Occup	ation	odina	16b. Kind of	f Business	/Industry
important; It from 27 is marked other train institlet, any Injury or other traumatic event, the Medical Exa once. To Be Completed by	Elementery/S	econdary (0-12)	1	ege (1-4or 5+)	life			during most of w	UIKING			
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or other traumatic event, the Mr. To Be Comp		ne (First, Middle,	Last)						am <i>e (First, Midd</i>		name)	
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			State of Maryla		tificate of			giene Reg. No. 99		1129
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	Examiner Funeral Director	5. Social Security Number 6. S 220–44–8136	Regional	Hospi :. lest birthdey) Yrs.		1		Prir	nce	George's ace (Steta or Foreign ny) any
	wo m	Usuel Residence of Decedent 10a. Stata 10b. County	10c. C	Sity, Town or Loc	cation				10	d. Inside City Limits
	the Merylen 28a-1 show northed at	MD Anne Aru	ndel La	urel						1 ☐ Yes 2 ☐ No
	iter death with the Meritime 23a or 28a-1 since must be notified.	10e. Street end Number 8361 Brock Bridge	Road		10f. Zip Code 20724	T,		10g. Citizen of V USA	Whet Count	ry?
020	ors e	3 ☑ Widowed 4 ☐ Divorced	12. Was Decedant Evar in the Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Give Year or Dates:	If	Vas Decedent of H Yas, specify Cub ☐ Yes 2 XNo	lispanic Origin? (an, Maxicen, Pua Specify:	Specify Yas or No- irto Rican, etc.)		ce - Amarica ck, White, e y: Whit	etc.
21215-0020	led within 72 hour lygiene. The then "nature! it, the Medical E.	15. Decedent's E (Specify only highest gre Elementary/Secondery (0-12)		(Give I	ent's Usuel Occup kind of work done O NOT use retire	petion during most of w d)	orking	16b. Kind of B		ustry
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Mar	d 2 should be end hend hend traum	19a. Informent's Neme/Relationship (Joan Goudy /niece					Ru <i>ral Rou</i> te Numbe Catonsvil			
	E TO N	20a. Mathod of Disposition		Pleca of Dispos	sition (Neme of	-	Date	20c. Location	-	
mo	y or	1 Burial 2 Cremation 3 2 4 Donation 5 Other (Specif			etory or other ple Nationa		4/23/99	Arlingt	on. V	irginia
Baltimore,	permit. Page Depertment of Important: If any Injury or once.	21. Signature of Funeral Service Loss	-	22. Do	Nama and Addra	ss of Facility Funeral	Home, P.	Α.		
	Physician /Medical Examiner	23a. Part1. Enter the state of companies of companies of control of the control of contr	· Acute		CARUL		N FAR		i	Approximete Intervel Between Onset end Death
68760,	cate be executed physician end s the bunel-trensit	Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest	С.	or as e consequ						
Box 6	=		d						1	
P.O. E	requires that the death certifies some signed by the ettending hould be deteched for use extend by Physiclan/Me	Pert II. Other significant conditions of	ontributing to death but not re	sulting in the un	derlying ceuse gi	ven in Pert I.		obacco use co Yes 2 No	ontribute to 3 ☐ Prob	the cause of deeth?
Records,	> 00	Hypo tens	Ion	.05 (6		4		an eutopsy med?	ave	re autopsy findings vilable prior to inpletion of cause leeth?
	certificate has breactor, page 2 s		uote CER	EBRI	WASCHI		euse 101			Yes 2□ No
Vit	Physician: this certific ral director,	25. Wes case referred to medicel exeminer? 1 ☐ Yes 2 ☑ No	Hospital:	T EB/Outpetiest	3 DOA Oti	ner _	eeth (Check only of Home 5 ☐ Resid		nor (Snacih	,
n of	fler this uneral on: T	27. Manner of Deeth	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe			,
Division of Vital	To the Hospital or Attending Physical Land Committee of the Funerel Director: Atter this completely filled in by the funeral draw Medical Certification: To Medical Certification: To	2 Accident Invastigation 3 Suicide 6 Could not b 4 Homicide determined		home, ferm, stre		Yes 2□No	28f. Location (S City or Tox	Street end Numi vn, State)	ber or Rural	Route Number,
	ne Hospital ne Funerel pletely filled edical C	29e. Certifier 12 CertifyIng Ph (Check only 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin end menner stated.	owledge, death etion end/or inv	occurred et the ti estigation, in my	me, date end ple opinion, deeth oc	ce, end due to the curred et the time,	ceuse(s) end m date and pieca,	anner es ste end due to	eted. the cause(s)
	within To the comple	29b. Signature and title of certifier	A. Wave	sim	29c. Licans	sa number 3916		29d. Data signe	Z 1 1	999 999
_	1	30. Name end eddress of person who	completed cause of deeth (Ite	m 23e) (Type, F	ce Ceary	Stha	urel, In	0 207	207	
	State Registrar	31. Date filed (Month, Dey, Year)	32. Registrer's Sign	gature g.	Span	les	ŧ			



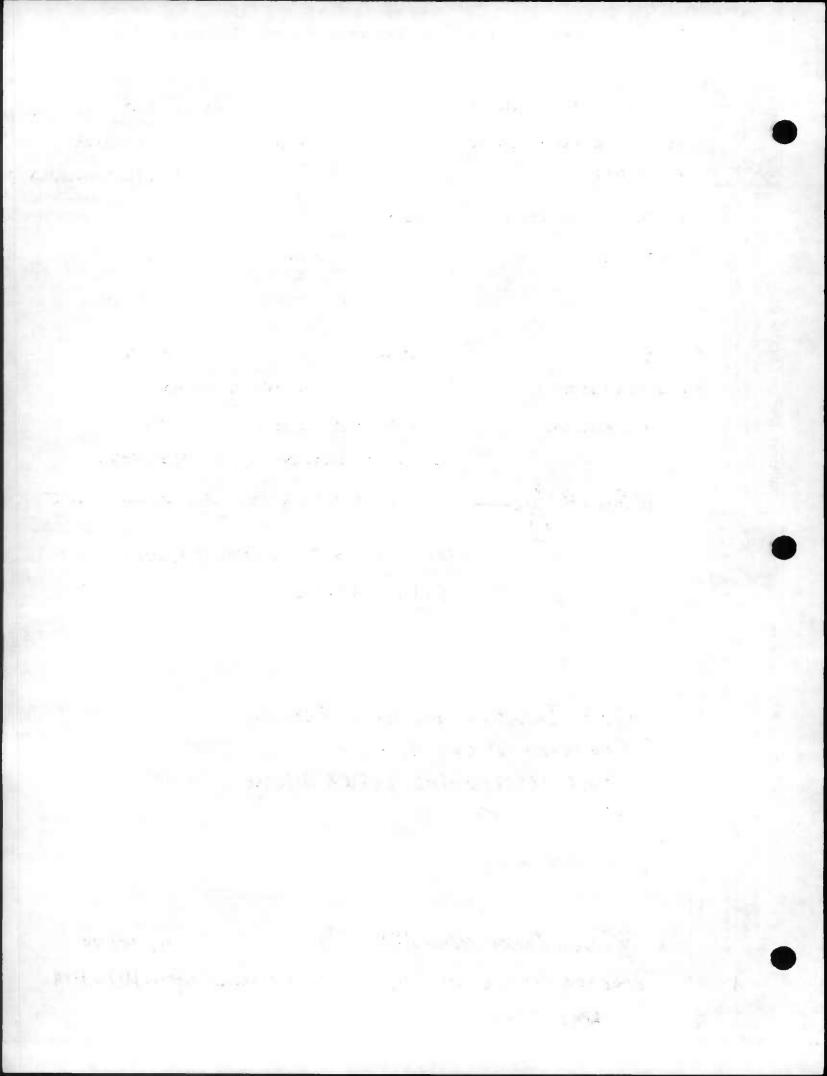
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth **Physician** MAE DECAMILLA 18 1999 April 12:50 am * /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dev. Year) Funeral 1□ M 257F Hours Yrs. 118 03 6116 86 Director Aug 18, 1912 | Rochester, NY Usuel Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours efter death with the Maryland Dependent of Health and Mentel Hygiene. Immortant: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Maryland any injury or other traumatic event. 10e State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Harwood Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4187 Solomons Is. Rd. 20776 USA Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ₹ No If Yes, Give ₹ Year or Dates: 14. Race - American Indian. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Merried 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) homemaker own home 8 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) John B. Camardo Antonia M. Cisterna 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Janis L. Rietschel 904 Judge Ct., West River, MD 20778 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 4-19-99 Metropolitan Crematory Alexandria, VA 21. Signature of Funeral Service License 22. Name end Address of Fecility William R Rausch Funeral Home, P.A., Owings, MD 20736 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one beuse on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Ceuse (Final diseese or condition resulting in death) with RENAL FAILURE Examiner Examine DEHYPRATION physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or es e consequence of): 98 esn Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. signed by the e 23b. Did tobacco uea contribute to the cause of death? Gastro Intestrual bleeding, 1 Yes 2 No 3 Probably 4 Unknown Dementia Ag 24b. Were eutopsy findings evailable prior to 24e. Wes en autopsy Completed CORONARY ARTERY DISEASE completion of cause of deeth? page 2 s GASTROESOPHAGEAL REPUX DISEASE 1 ☐ Yes 2 ☐ No certificete or Attending Physician: funeral director, 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28d. Describe how injury occurred 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. injury et Work? Certification: 1 Matural 5 Pending efter deeth. 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 24 hours e Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29e. Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number Barbona Paxson Whom MD 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 1684 Village Green Croffon MD 21114 BARBARA PASSON URBAN, MID

State Registrar 31. Dete filed (Month, Dey, Year)

APR 2 1 1999

32. Registrar's Signeture

B. Sparks



Piease Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Amended#17 perFH G771 5/13/99 EW 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Samuel Cooper 2300 101 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 9435 MURKIRK LAUREL ROAD PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. Month, Day. 5/1/24 7. Aga (In yrs. last birthday) 5. Social Security Number Birthplaca (Stata or Foreign Country) 1∰M 2□F Months 74 Yrs. Carolina 194-18-2499 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. P.G. Laurel 1 ☑Yes 2 ☐ No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 9325 Muirkirk Rd. # T-2 20708 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 2 Yes 2 No If Yes, Give Year or Dates: 52-68 1 ☐ Never Married 2 X Married 1 Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry D.C. Government Elementery/Secondery (0-12) College (1-4or 5+) 4 yrs D.C. Recreation Dept. Facility Manager 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Pearl Townsend Joseph John Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7616 Swan Terr., Landover, Md. 20785 Ethern W. Cooper/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veterans Cem. 4/20/99 Cheltenham, Md. 21. Signature of Funeral Servica Licanses H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) . HYPERTENSIVE ARTERIOSCUEROTIC CARDIOVA SCULAR DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were eutopsy findings evellable prior to completion of cause of death? 2 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examinar? 26. Place of Deeth (Check only one) Other: 4□ Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 5 Pending investigation 1 Tyes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funerai

by

Completed

Be

Funeral

Director

"natural", or itema 23a or

other than "natur

Item 27

important: If it any injury or o

permit. Pages 1 end 2 should be filed within 72 hours eftar death Departmant of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Itema 23.

3altimore, Maryland 21215-0020

P.O. Box 68760,

Division of Vital Records,

with the Maryland

Examiner physician end the burial-trensit Physician/Medicai 9SN Š Completed page 2 Be Certification: To

thet the death certificete be executed signed t Attending Physician: this funeral After death. ector: Direc

Hospital 24 hours within 2

ò

Registrar

edicai

nd address of person who completed GOLLE MARIO

6 Could not be determined

duse of death (Item MD JK

28a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s)

29d. Date signed (Month, Day, Year)

HOSPITAL DRIVE, CHEVERLY MAKYLAND 20785

28f. Location (Street and Number or Rural Route Number, City or Town, State)

APR 1 3 1999

2 Accident

4 Homicide

(Check only

29b. Signature a

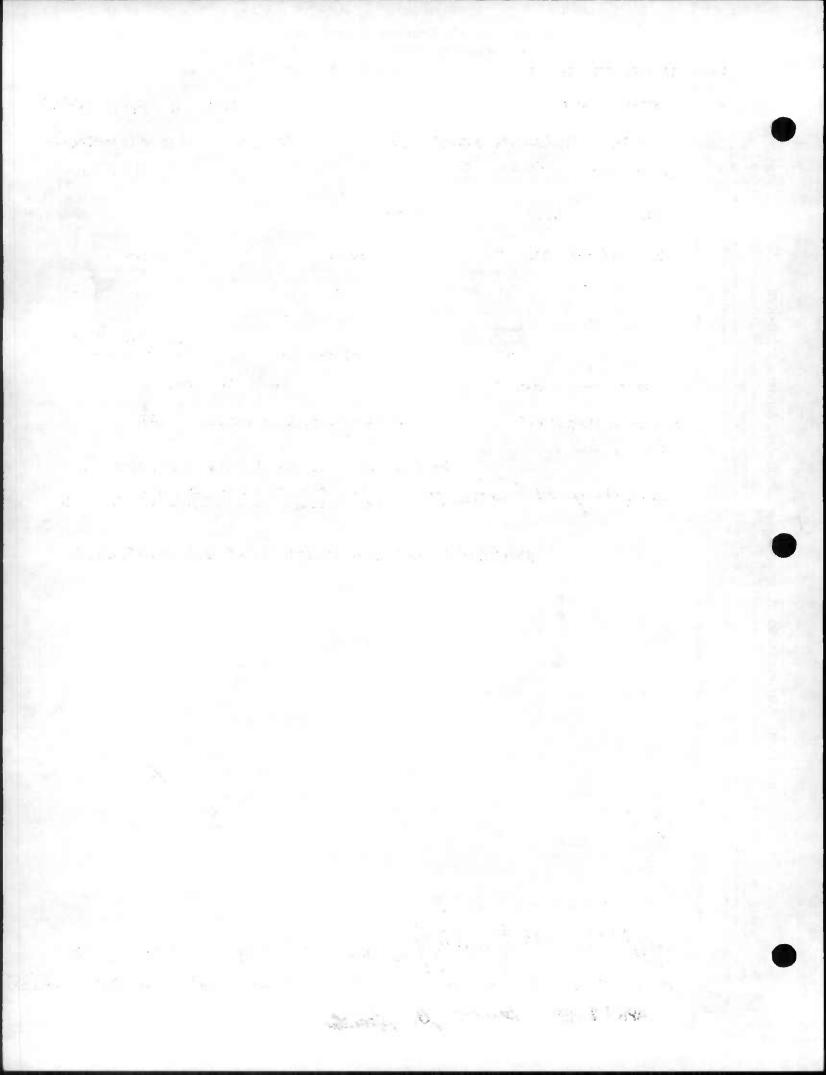
3 ☐ Suicide

29a. Certifier

32. Registrar's Signature

3001

28e. Placa of Injury - At homa, ferm, street, factory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene 9 9

				C	entificate o	t Death		Reg. No.		
ı	Dhysisian	1. Decedent's Neme (First, Middle, La	st)				2. Dete of Month	Deeth Dey	Yeer	3. Time of Death
	Physician /Medical	Oscar	D.	Dallaco	lua		Apri.		9	10:31 P.M.
	Examiner	4e Fecility Neme (If not institution, given Malcolm Grow Me		ter			own, or Location of D Springs	Princ	y of Deeth e Geo	rge's
r	Funeral	5. Sociel Security Number 6. S		e (In yrs. last birtho	ey) If Under 1 Ye Months Der	ar If Under		Birth , Dey, Yeer)		plece (Stete or Foreign ntry)
L	Director	171-09-1226 Usual Residence of Decedent	XM 2□ F 81	Yrs	. Months Dej	ys Hours	July	24,1917		sylvania
	Mend Mend	10a. Stete 10b. County		10c. City, Town o	Location				1	Od. Inside City Limits
	ges 1 end 2 should be filed within 72 hours efter death with the Meryland it of Heelth end Mental Hygiene. ** netural; or items 23a or 28a-f show or other traumatic event, the Medical Examinar roust be notified at To Be Completed by Funeral Director.	Maryland Prince G	eorge's	Suitlar						1)∏Yes 2 □ No
	Oire	10e. Street end Number			10f. Zip Code			10g. Citizen of		ntry?
	eth v	5916 Cable Ave.			207			US		
	ter de iner i	11. Marital Stetus 1 □ Never Merried 2 ☒ Married	12. Was Decedent Armed Forces?	to 10/2	If Yes, specify C	uben, Mexicai	igin? (Specify Yes on n, Puerto Rican, etc.) 14. Ha	ce - Americ eck, White,	
21215-0020	al', or	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Yeer or Detes:	1945	1□ Yes 2□	lo Specify:		Speci	y: Whi	te
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121	ed within 72 hou ygiene. Nor than "neture it, me Medical E	Elementary/Secondary (0-12)	College (1-4or 5	i+) lii	e. DO NOT use ret	ired)				
	Per th	12th		Gra	phic Illi		OT er's Name (First, Mid			vernment
and	ntal H ad out	17. Father's Neme (First, Middle, Last) Giovanni Da					ers Name <i>(First, Mic</i> ttoria		me)	
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Ma	end 2 s eelth en n 27 le ier trau	Adele Dallacqua/V	**	_	me as it		07 07 710/07 710	ambor, only or rown	1, Ototo, 2-1p	, 0000)
re,	es 1 end of Heelth I Item 27 r other tr	20e. Method of Disposition		20b. Place of Di	sposition (Neme of cremetory or other p	olece)	Date	20c. Location	- City or To	own, State
Baltimore,	oermit. Pages 1 end Depertment of Heelit Important: If Item 27 eny Injury or other ti enge.	1 Burial 2 Cremetion 3 Other (Specific			viour Ce		4/15/99	Bethle	hem,P	Α.
alti	permit. Pag Depertment Important: If eny injury o	21. Signature of uneral Service Licer	psee /		22. Name end Add		•			
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	Physician /Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death)	· Lymp	H6 M5	2 ABD (sequence of):	0 M) 0	BL		4	Onset end Deeth
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ox 68760,	n certificate be executed and use as the buriel-transit	resulting in death) Last	d	Due to (or es e con	sequence of):					
B.	the etter the etter thed for a	Part II. Other significent conditions of	ontributing to death be	ut not resulting In th	e underlying cause	given In Pert	I. 23b.	Did tobacco uee c	pntribute to	o the cause of death?
P.0.	± 60 F	SEVERE ANEN	. /	HEMOT	HERAT	24		1 Yes 2 No	3 Pro	bably 4 Unknown
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COL	The law requireste has been spage 2 should	the vertensus	of					performed?	ev	eilable prior to empletion of cause
Re	certificate has rector, page 2	(1						Yes 2.00 No		deeth?
tal						26 Place	e of Deeth (Check of		11	☐ Yes 2☐ No
of Vital Record	Physicien: The lav this certificate hes ral director, page 2	examiner?	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpe	tient 3 DOA	Other	ursing Home 5 F		her (Specil	(v)
	ding Phys h. After this funeral di	27. Manner of Deeth 1 Naturel 5 Pending investigation	28e. Dete of Injui (Month, De)	y 28b. Tim	e of 28c. ir		28d. Descr	ibe how injury occu		,,
Division	To the Hospital or Attending Phwithin 24 hours efter deeth. To the Funeral Director: After this completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be	9	ury - At home, ferm c. (Specify)	street, factory, office		28f. Location	on (Street end Num Town, Stete)	ber or Rura	al Route Number,
	he Hospitu in 24 hours he Funera pletely fille edical (ysician: To the best on niner: On the besis of end manner sta	exemination end/o						
	of the complete of the complet	29b. Signature and title of certifier	The state of the		29c. Lice	ense number		29d. Date sign	ed (Month,	Dey, Year)
	-	> // Meliared	TRen	en	1 2	4945	5	Apon	17.	1999
	(16)	30. Name end eddress of person who	completed cause of d	eath (Item 23e) (Ty	pe, Print)	1,,,		THILL	- 12	1111
	0	Michael Levine,				inton,	MD. 20735			
	State	31. Dete filed (Month, Day, Year)		er's Signature	1					

A DESCRIPTION OF THE PERSON

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State of Manuand / Department of Health and Mental Hygiene

	Decedent's Neme (First, Midd	le. Last)		001		3 01	Death	1	2. Dete of De	Reg. No. eth		3. Time of Death
ician dical	Mary Frances	Dempster				Ш			Month April	Dey	Year	1500
niner	4a Facility Name (If not institution		er)						cation of Death			
	Levindale Hosp						Balt				ltimo	
	5. Social Security Number 218-26-9010	6. Sex 7. 1 □ M 2 🕅 F	Age (In yrs.	last birthday) Yrs.	Months Months	Deys	If Under 2	Min	8. Dete of Bir (Month, De July 24	v Year)	9. Birthpl Count Vir	ace (Stete o <i>r Foreig</i> n try) ginia
	Usuel Residence of Decedent 10a. Stete 10b. County	,	10c. Ci	ty, Town or Lo	cation						10	Od. Inside City Limits
to	Maryland Balt	imore		Re	ister	rstor	νn					1 Nes 2 No
Director	10e. Street and Number	. Zimo I C		110	10f. Zip					10g. Citizen ot V	Whet Count	try?
-	67 Benson Lan	е				2113	6			U.S.A		
1	11. Merital Status 1 Never Married 2 Mar 3 Widowed 4 Divorce	If Yes Give	es? M No				lispanic Origi an, Mexican, Specify:	in? (Spe Puerto	ecify Yes or No Rican, etc.)	14. Rac Bled Specify	e · America ck, White, e	etc.
ed by		nt's Education	95.	16a. Deced	dent's Usu	el Occup	pation			16b. Kind of Bu		
Completed	(Specify only higher Elementery/Secondary (0-12)	st grade completed) College (1-4)	or 5+)	(Give	kind of wo DO NOT u	ork done	during most	of worki	ing	Electrical Control of the Control		ge's Count
5	11	College (1-4		Scho	ool B	us D	river			Educati	on Sy	
0	17. Fether's Neme (First, Middle,									Maiden Sumen	ne)	
2		Ferrell		1			Cla			amb		
	19e. Informent's Name/Reletions Alice Mae Watk		r							er, City or Town, Marylar		Code) 1136
	20a. Method of Disposition 1 X Burial 2 ☐ Cremetion	3 □Damoval from St	Contract of the Contract of th	Place of Dispo cemetery, crer	netory or o	me of other ple	ce)	1	Dete	20c. Location -	City or To	wn, Stete
	4 Donetion 5 Other (S			yland V	eteran	s Ce	metery	04	+/15/99	Chelter	nham,	Maryland
	21. Signeture of Funeral Service	Licensee		Ga	asch'	s Fu		Hom	e, P.A. ue, Hya	ittsvill	e,MD	20781
	23a. Pert1. Enter the disease, o shock, or heart tailure. Lis Immediate Cause (Final disease or condition	r complications that cau t only one cause on eed	sed the dee h line.	Λ.	er the mod		ng, such es c		,,	rrest,	8 8	Approximete Intervel Between Onset end Death
	resulting in death)	a	Due to (or es e consec		:	1	1.10	1		1	
	Property of	b		ASC	VP						1	Tears
ai LAGIIIII	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	C		or es e conseq								/
/Medical	that initiated events resulting in death) Last	d	Due to (d	or as e conseq	juence of):							
5	Part II. Other significant conditi	nne contributing to doe	h hut not rec	rulting in the u	adarhiina i	cause oi	en in Part I		23h Did	tobacco use co	otribute to	the cause of death
Physician/M						oudo gii						bebly 45 Unknow
			5						24e. Was	en eutopsy ormed?	eva	ere autopsy lindings allable prior to mpletion of ceuse deeth?
2									10	Yes 2 2 No	10	Yes 2 No
ò									1			
e Completed by	25. Wes cese referred to medical	11					26. Place	ot Deeth	h (Check only	one)		
o Be Completed by	25. Wes cese referred to medica examiner? 1 \(\text{Yes} \) 25 No	Hospitel: 1 Sing	atient 2] ER/Outpatier	nt 3 🗆 D	OA Ott	ner	11.0		one) dence 6 Oth	ner (Specif)	y)
Be Completed by	examiner? 1	Hospitel: 1 Sing 28a. Date of (Month, gation		ER/Outpatier 28b. Time of Injury		28c. Inju	ner: 4 Nur	sing Ho	me 5 Resi			y)

State Registrar

30. Name and address of person who completed cause of death (Hom 23a) (Type, Print)

Jef Zibel MD 7220 Park Heights Are Bathe MD 21208

037573

1998 January 1898 1898

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3 Time of Death 2 Date of Deeth Month **Physician** DARNELL SK 4c. County of Death uarles 4:30 Am APRIL /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not Institution, give street and number) Examiner Tolowa Park, Mi) Adventst HOSPHON(Washington Montgover If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 □ F Deys 231-30-0166 1932 Washington, DC Director Usuel Residence of Decedent with the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at 1 Yes 2 □ No Directo Maryland Prince George's Colmar Manor 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3412 39th Place 20722 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health end Mental Hygiene.
rtt: If Itam 27 is marked other than "natural", or Itema 23. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11 Maritel Status 1 N Yes 2 No
If Yes, Give
Yeer or Detes: 1948-56 1 ☐ Never Merried 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Architect of Elementery/Secondary (0-12) College (1-4or 5+) Plant Manager the Capitol 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) George Francis Darnell Sally Womack 2 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Jerry W. Darnell - Son 5733 Crestwood Place, Riverdale, Maryland 20737 Important: If itam 2 any injury or other 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Page Department of 04/14/99 Cheltenham, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) MD Veteran's Cemetery 22. Name and Address of Facility
Gasch's Funeral Home, P.A. 21. Signeture of Funerel Service Licenses 4739 Baltimore Avenue, Hyattsville, MD 20781)aor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Onset end Deeth Physician Immediate Ceuse (Finel disease or condition resulting in deeth) rivicaicai Examiner Examiner end I-trensit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest physician e Bueco Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of) 50 use Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Cellulitis 1 Yes 2 No 3 Probably 4 Unknown þ Chrows Cobstructore Pulmonery Disease 24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 24e. Wes en autopsy Completed rentificate hes b 1 ☐ Yes 2 No or Attending Physician: 25. Wes cese referred to medical examiner? Be 26. Piece of Deeth (Check only one) To Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpetient 3 DOA funerel 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: 1 Neturel 5 Pending 2 No 1 ☐ Yes investigetion 2 Accident efter death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 24 hours 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, end due to the ceuse(s) end menner steted. 29a. Certifie To the Hosp within 24 hor To the Fune completely fi edical (Check only one) 29b. Signeture end title of comities 29c. License number 29d. Date signed (Month, Day, Year) Dhysician completed ceuse of deeth (Item 23e) (Type, Print) 30. Neme and eddress of person who 7925 Greenbelt Durve, SulteT4, Greenbelt 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 1 2 1999 State Registrar

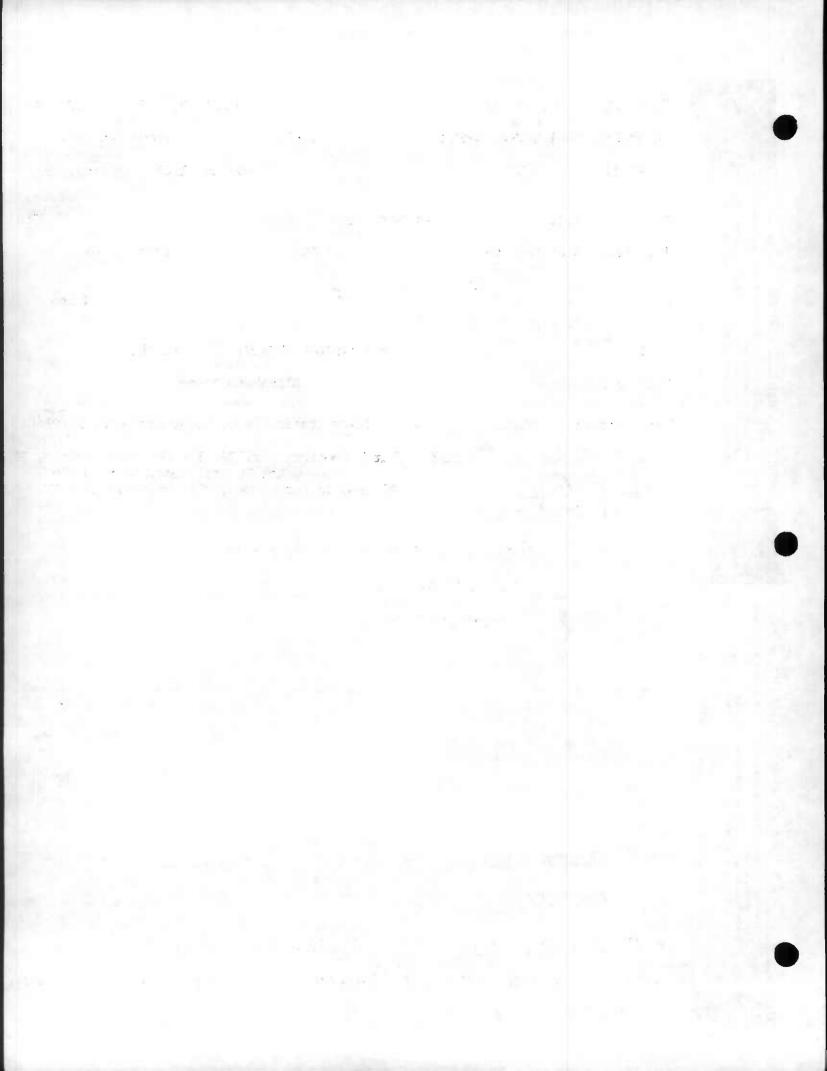
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State of Maryland / Department of Health and Mental Hygiene

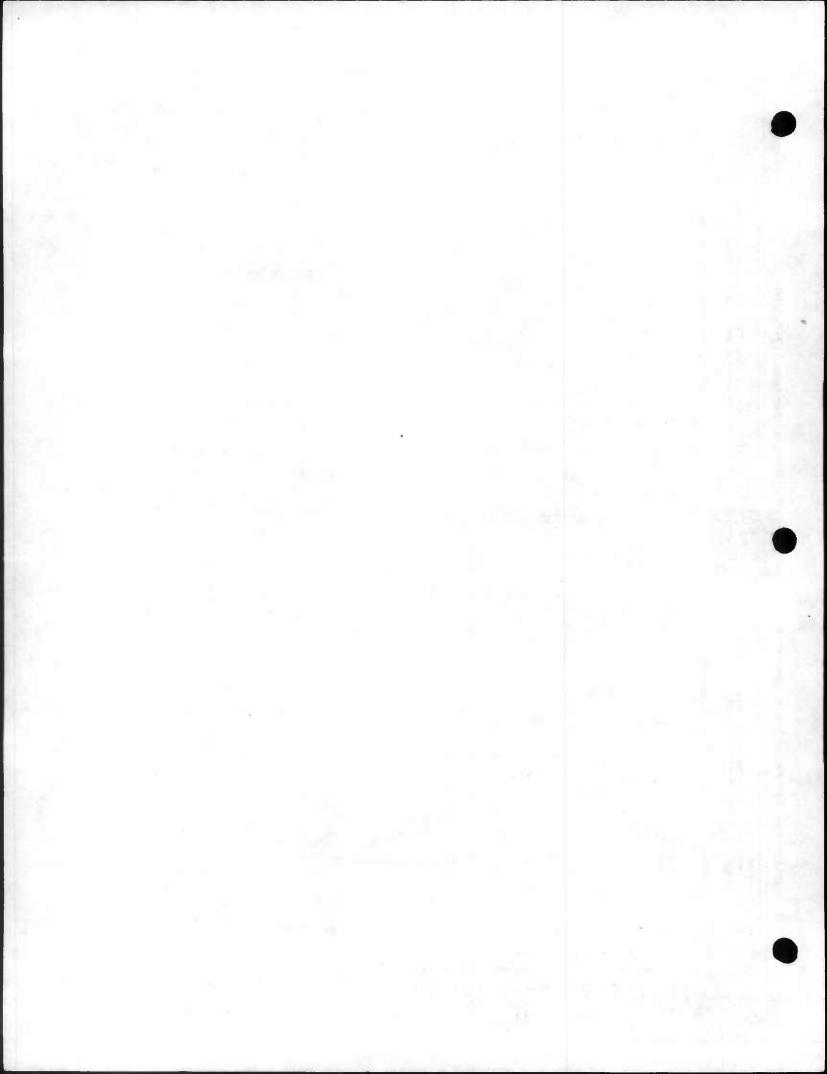
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death April 19, 1999 **Physician** Elizabeth M. Evely 1:05 A.M - /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Heartland Health Care Center Adelphi Prince George's H Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Y May 30, 1 5 Social Security Number 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Yrs. 91 Ashland, PA 579 38 4452 Director Usuel Residence of Deceden with the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturet", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at 1 □ Yes 2 □ No Directo MD P.G. Upper Marlboro 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1077 Largo Road Apt 409 20774 United States Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 O No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 end 2 should be filed within 72 hours efter of the off Heelth and Mental Hygiena. Int: If Item 27 is marked other than "naturat", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2XXNo Specify: by 3℃ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail (SALES PERSON) Retail 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Patrick Scanlon Elizabeth Price 2 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12700 Duley Station Road, Upper Marlboro, Maryland Barbara Amangum (NIECE) 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dale XXBuriel 2 Cremetion 3 Removal from State Injury or Depertment of Christ Church Cemetery April 24, 199 Fountain Springs, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecilityee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service License any Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Intervel Between Onset and Death **Physician** CARDIDPULMOREARY ARREST /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Due to (or as a consequence of): e EUMONELA Examiner physician end the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Ihat Initiated events resulting in death) Lest Due to (or es e consequence of) requires that the daath certificate be axe SCRTICEMIA Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): 200 esn Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4∑ Unknown signed I ò 24b. Were autopsy findings aveilable prior to Completed 24a. Wes en autopsy performed? peeu completion of ceuse of death? hes page 2 cartificeta 1 Tes 2 No 1 Yes 2 No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this cartifice director, 25. Was case referred to medicel examiner? Be 28. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) completaly filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) To the To the To the I 29d. Dale signed (Month, Dey, Yeer) 29b. Signature and the of certifier 29c, License number MI 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) PARKWAY GREET MARYLAND NYGIAKA 31. Date filed (Month, Day, Year) 32. Registrer's Signature State APR 2 0 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

				Ota	ite of it	nai yiai k		tificate o		a Wielitai II	Reg. No.		4 3 0
	T	-	1. Decedent's Name (First, Midd	lle, Last)						2. Date of D	Death		3. Time of Death
	Physiciar /Medica	-	Dolores J	. Ewin	19					Month	Day	99	18:05
	Examine	7	4a Facility Name (If not institution						4b. City, Town,	or Location of Dea	ath 4c. County	of Death	
М			University of M	aryland	1 me	dical	Cente		Salt	more.	Balti	more	City
	Funeral Director		5. Social Security Number 219-03-2761	6. Sex 1 □ M 2		Nge (In yrs. la 76	ast birthday) Yrs.	If Under 1 Yes Months Day		Irs. 8. Date of 8 (Month, L			place (State or Foreign ntry) Land
	¥	1	Usual Residence of Decedent 10a. State 10b. Count	,		10c. City	. Town or Lo	cation					10d. Inside City Limits
	with the Maryland a or 25s-f show the notified at	6		Anne '		Ches							1 ☐ Yes 2 ☐ No
	176 176	Director	10e. Street and Number	Anne	5	Ches	Lei	10f. Zip Code			10g. Citizen of	What Cou	ntry?
	S S S S S S S S S S S S S S S S S S S		1906 Bayside D	rive				21619			U.S.A		
050		by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Wa	s Deceder ned Forces Yes 2 \(\) Yes, Give ar or Dates] No				(Specify Yes or Nerto Rican, etc.)		ce - Ameri ck, White,	
Maryland 21215-0020	atura salis	0	15. Decede	nt's Education			16a. Deced	lent's Usual Occ	upation		16b. Kind of B		
218	Media 7	Completed	(Specify only high Elementary/Secondary (0-12)	1	<i>leted)</i> llege (1-4o	(54)	(Give life. I	kind of work dor DO NOT use reti	e during most of red)	working			
2	od within	100	6		ogo (t. to		Homen	aker			Self		
P	STATE OF THE PARTY		17. Father's Name (First, Middle	Last)					18. Mother's I	Name (First, Middle	le, Maiden Sumar	ne)	
ya	Men Men	0	James cancer	Joncza	k	31111			Elsie	Liszewsk	а		
ar	and and and and and and and and and and		19a. Informant's Name/Relation		nt)					Rural Route Num		, State, Zi	o Code)
	1 and 1 Health em 27 Wher tr		John Ewing - S	on		DOL DI		Reedy	Road, Ma	rydel, M		0>	
Baltimore,	200		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (-		I from Stat	e Ce	metery, crer	natory or other p	F	eb. 24, ter LLC.	20c. Location 1999 Stevens		
Balt	pemil. Peg Depertment Important: I eny Injury o		21. Signature of Funeral Service	Wich	hier	ing	- 22 Fe	Name and Add	ress of Facility Helfenbe		nam Fune		Home P.A.
		1	23a. Part 1. Enter the disease, of shock, or heart annua. Lis	r complications t only one caus	that causi ie on each	ed the death.						1019	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		Sep	Due to (or	Sho	ck					1 month
			resulting at deality						A			1	
	be to the			b	ノンナー	a-A	bdom	: na 1 10	ifectio.			i	Imenth
_	fileste be executed physicien and se the burlel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		-		as a consec					ŀ	
68760,	physicies the burd		Cause (Disease or injury that initiated events	с	1000	plant	ret	uence of):	tis				thom
	2 00	_	resulting in death) Last		^							ŀ	1
Box	ulpu	2		d	ho	ric R	enal	Jai. Iu	-e			<u> </u>	year
-	the deeth cert y the ettending sched for use	5	Part II. Other significant conditi	ons contributin	g to death	but not resul	Iting in the u	nderlying cause	given in Part I.	23b. Di	d tobacco use co	entribute t	to the cause of death?
ls, P.O.	ned by the detach	y ruy	Resp: ratory	Fail	re					10	Yes 2 No	3 Pro	bably 4 Unknown
of Vital Records	The lew requires that the death certificate has been signed by the ettending page 2 should be detached for use and any other interests.	Detect	Coronary 1			sease	· PR				as an autopsy formed?	an an	fere autopsy findings vailable prior to ompletion of cause death?
I Re	elclen: The lew scarlificate has billirector, page 2 s	E	O:abetes	meil:	tu s					10	Yes 2 No	1	□Yes 2□No
/Ita	clen:		25. Was case referred to medic examiner?							Death (Check only	y one)		
5	2	2	1 ☐ Yes 2 ☑ No	Hospital	1 npa	tient 2 E	ER/Outpatier	K 3LI DOA		g Home 5□Re	_		()/
	offer death. Offector: After this in by the funeral dispersed on the f	ation:	E LI PROGRAMIE	ng igation	Date of In (Month, D	jury lay Year)	28b. Time of Injury	V V	jury at /ork? □ Yes 2 □ No	28d. Describ	e how injury occur	rred	
Division	re after death. el Director: After t led in by the funeri		3 Suicide 6 Could 4 Homicide deten	not be nined 28e.		njury - At hor etc. <i>(Specify)</i>		eet, factory, offic	8		(Street and Numi own, State)	ber or Rui	al Route Number,
	To the Hospital or Attending Ph Within 24 hours effer deeth. To the Funerel Director: After th completely filled in by the funeral	Calcal	29a. Certifier 1 Certifyi (Check only one) 1 Medica	Examiner: On	To the bes the basis d manner :	of examination	rledge, death on and/or in	occurred at the restigation, in m	time, date and play opinion, death o	ace, and due to th coursed at the time	e cause(s) and m e, date and place,	anner as	stated. to the cause(s)
	Within To the		29b. Signature and title of certifi	Br				29c. Lice	nse number		29d. Date signe	ed (Month,	Day, Year)
			William	C.Chi	~, n.	0.		D	1614-	7	21.	22/	99
			30. Name and address of persor	who complete	d cause of	death (Item					<u> </u>		
			William C. Chi	u, m.o.	Ucin	rersitu	ofm	wyland 1	medicals	ystem, Ba	Itimore,	no:	21201
	State		William C. Chi 31. Date filed (Month, Day, Year FEB		32. Regis	trar's Signat	ure	6 1		/			
	Registrar		FEB	5 1999	1	Olper	-	J. Sp	acks				



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of Maryland / Department of Health and Mental Hygiene	99	16	13	7
Certificate of Death Reg. No.				

and Prince and Prince nd Number Brooklyn Br itatus r Married 2 Married wed 4 Divorced 15. Decedent's Et (Specify only highest gray) y/Secondary (0-12)	Donald Le se straet end number) Hospital For Total Tot	last birthday) 8 Yrs. y, Town or Loc	If Under 1 Yaar Months Deys cation 10f. Zip Code 2070	Hours Min.	2. Dete of De Month April Docation of Death (Month, De	Dey 14, 19 4c. County Printh	of Deeth ICE Geor 9. Birthplace (Country) Marylan 10d. Ins	Steta or Foreign		
I Regional urity Number 6. S 0 0502 unce of Decedent 10b. County and Prince and Number Brooklyn Br eatus r Married 2 Married wed 4 Divorced 15. Decedent's E (Specify only highest gray y/Secondary (0-12)	Hospital Frame Control of the Contr	8 Yrs. y, Town or Loc	Months Deys eation 10f. Zip Code 2070	I aurel If Under 24 Hrs. Hours Min.	8. Dete of Bird	Prir th ty, Year)	of Deeth ICE Geor 9. Birthplaca (Scountry) Marylan 10d. Internal	ges Steta or Foreign d		
urity Number 6. S 0 0502 Ince of Decedent 10b. County and Prince of Number Brooklyn Britatus r Married 2 Married wed 4 Divorced (Specify only highest gray/Secondary (0-12)	Georges 10c. City Georges Lidge Road 12. Was Decedent Ever in U, Armed Forces? Now Yes, Give Yaar or Detes: 1944,	8 Yrs. y, Town or Loc	Months Deys eation 10f. Zip Code 2070	Hours Min.	8. Dete of Birl (Month, De	th y, Year)	9. Birthplaca (Country) Marylan 10d. Inc.	Steta or Foreign d side City Limits		
and Prince nd Number Brooklyn Br tatus r Married 2 Married wed 4 Divorced 15. Decedent's E (Specify only highest gra y/Secondary (0-12)	idge Road 12. Was Decadent Ever in U, Armed Forces? 172Yes 2 □ No 174s, Give Yaar or Detes: 1944	aurel	10f. Zip Code 2070	7		10g. Citizen of V	10d. Inc	side Clty Limits		
and Prince nd Number Brooklyn Br tatus r Married 2 Married wed 4 Divorced 15. Decedent's Et (Specify only highest gra y/Secondary (0-12)	idge Road 12. Was Decadent Ever in U, Armed Forces? 172Yes 2 □ No 174s, Give Yaar or Detes: 1944	aurel	10f. Zip Code 2070	7		10g. Citizen of V	10			
Brooklyn Br iatus r Married 2 Married wed 4 Divorced 15. Decedent's Et (Specify only highest gra y/Secondary (0-12)	12. Was Decedent Ever in U, Armed Forces? ***TYYes 2 No if Yes, Give Yaar or Detes: 1944	S. 13. W	2070	7		10g. Citizen of V				
r Married 2 Married wed 4 Divorced 15. Decedent's E. (Specify only highest gra y/Secondary (0-12)	12. Was Decedent Ever in U, Armed Forces? ***TYYes 2 No if Yes, Give Yaar or Detes: 1944	S. 13. W		7			Whet Country?			
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(Specify only highest gra y/Secondary (0-12)	ducation		ent's Usual Occu	pation		16b, Kind of Bu	usiness/Industry			
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Nema (First, Middle, Last,)			18. Mother's Nam	e (First, Middle,					
rd Fulto				Edna	Beall					
nt's Name/Reletionship (19b. Mailing	g Address (Stree	et end Number or Rur		er, City or Town,	Stete, Zip Code)		
Donald L. Fulton, Jr. Son 6911 Brooklyn Bridge Road, Laurel, Mary										
of Disposition el 2 □ Cramation 3 □ etion 5 □ Othar (Specification) e p) Funerel Sarvice Llog	y) I	vy Hill	latory or other pla L Cemete Name end Addr naldson	ry 4,	/17/99	212 m ₂ 1	Maryla bott Av	enue		
or heert failure. List only euse (Finel ondition	e. Sepsis			ing, such as cardiac	or respiretory e		Apprinten Onse	oximate vel Between et and Death days		
	Urinary	tract i	infectio	n						
list conditions, ig to immediate if Underlying ese or Injury	Due to (o	r es e consequ	uence of):							
events	Dua to (or	r as a consequ	uance of):							
elanificant conditions	contributing to death but not rec	ulting in the un	derivina cause a	iven In Pert I	23h Did	tobacco usa co	ntribute to the c	rause of death'		
			usnying couse g	ivon in rotts.						
noma of uri	nary bladder				24a. Wes	en eutopsy ormad?	available	ion of ceuse		
insufficie	ncv				10	Yes 212 No	1 ☐ Yes	2 No		
	no ₁			26 Plece of Deal						
7	Hospitel:	FR/Outpatient	3 DOA	thor			er (Specify)			
f Deeth rel 5 Pending	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inj	ury et ork?						
determined	286. Place of injury - At no	ome, ferm, stre	et, factory, office				per or Rural Rou	te Number,		
	ysician: To the best of my knowniner: On the basis of examiner		accurred at the							
TO THE PROPERTY OF THE PROPERT	Ceuse (Finel conditions of death) I list conditions, no to immediate ar Underlying less or Injury levents deeth) Lest I significant conditions of anonia, obstructions of uriling insufficies referred to medical conditions of the conditions of th	Couse (Finel condition death) Pue to (or Urinary bull to (or Urinary bull to (or Urinary bull to (or Urinary bull to (or Urinary bull to (or Urinary bull to (or Urinary bull to (or Urinary bull to (or Urinary bull to (or Urinary bull to (or Urinary bull to (or Urinary bull to (or Urinary bull to (or Urinary bull to (or Irinary bull to (or Irin	Couse (Finel condition death) Bue to (or es e consequent or underlying lesse or Injury levents deeth) Lest Couse (Finel conditions and the conditions contributing to death but not resulting in the underlying levents deeth) Lest Couse (Finel conditions and the consequent of the couper of the conditions and the conditions contributing to death but not resulting in the underlying levents deeth	Due to (or es e consequence of): Urinary tract infection Due to (or es e consequence of): Urinary tract infection Due to (or es e consequence of): Due to (or es e conseque	Due to (or es e consequence of): Urinary tract infection Due to (or es e consequence of): Urinary tract infection Due to (or es e consequence of): Urinary tract infection Due to (or es e consequence of): C. Dua to (or as a consequence of): d. Dua to (or as a con	Deuse (Finel condition death) Sepsis Due to (or es e consequence of): Urinary tract infection	Deuse (Finel condition death) Sepsis Due to (or es e consequence of): Urinary tract infection	Cause (Finel condition death) Pue to (or es e consequence of): Urinary tract infection Due to (or es e consequence of): Urinary tract infection Due to (or es e consequence of): Urinary tract infection Due to (or es e consequence of): c. Dua to (or as a consequence of): d. Dua to (or as a consequence of): d. Dua to (or as a consequence of): d. Dua to (or as a consequence of): d. Dua to (or as a consequence of): d. Dua to (or as a consequence of): d. Dua to (or as a consequence of): d. Dua to (or as a consequence of): d. Dua to (or as a consequence of): d. Dua to (or as a consequence of): d. Dua to (or as a consequence of): 1		

15+1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R.G. Bhojraj M.D. 704 Gorman Avenue #T-1 Laurel, Maryland 20707

Registrar

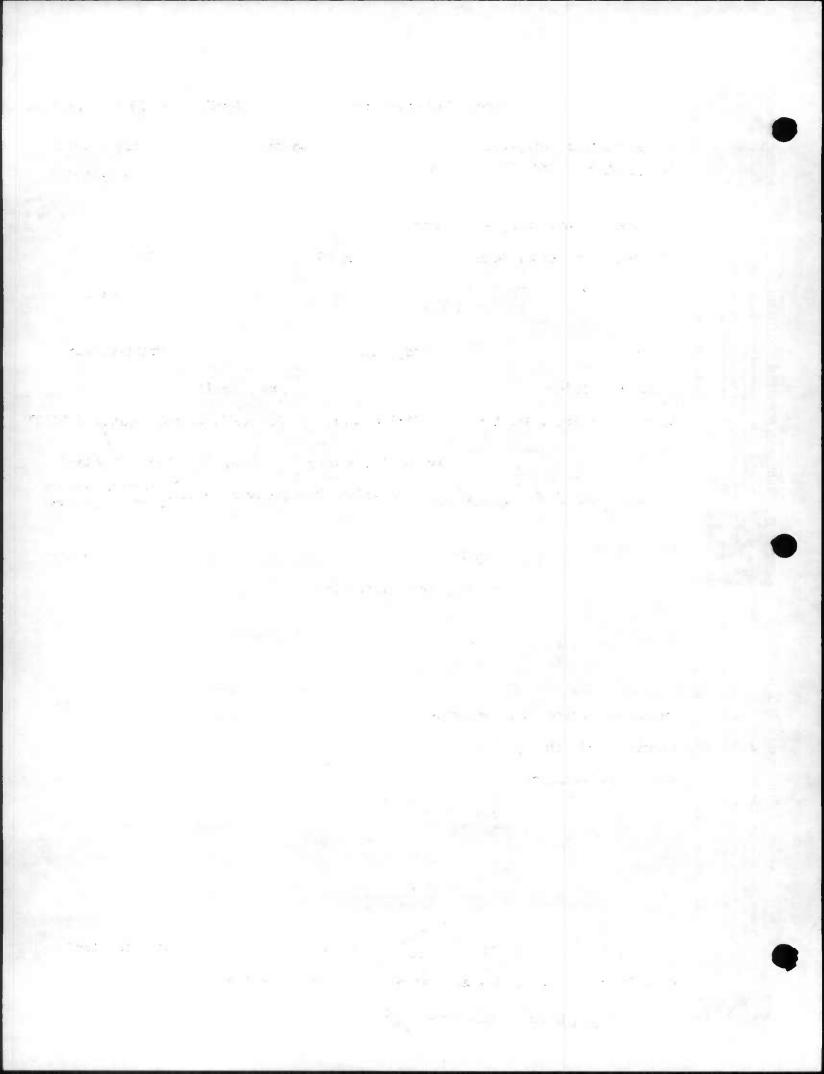
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32. Registrer's Signature



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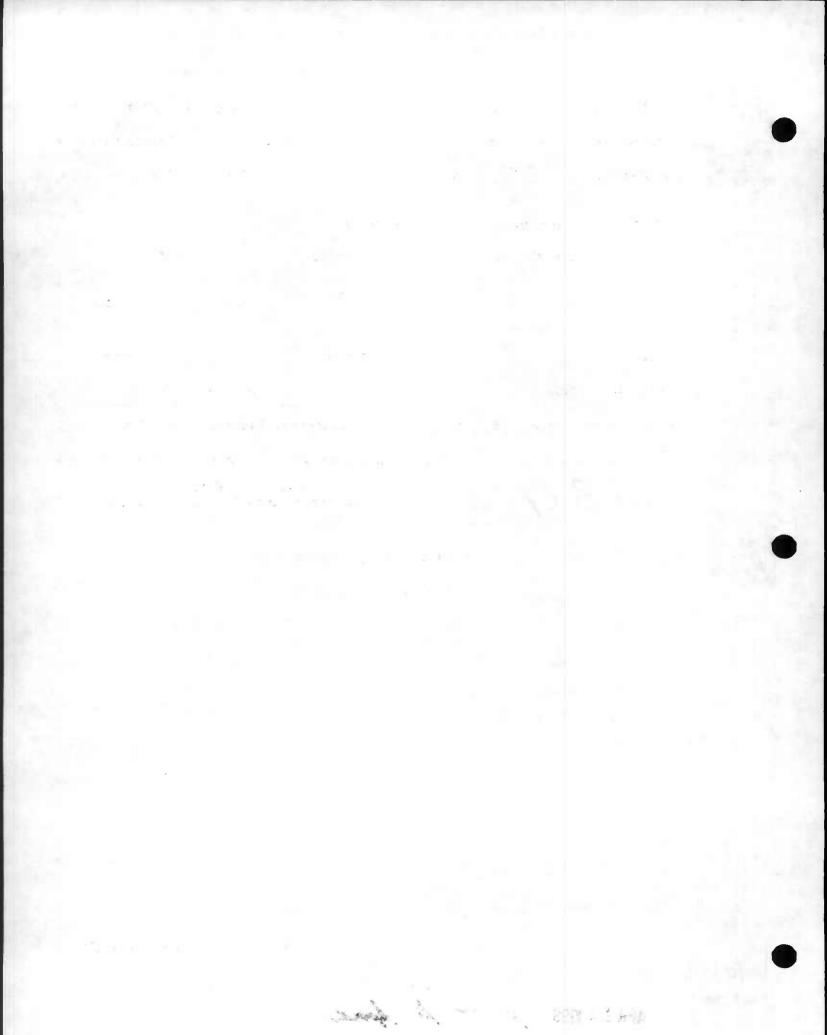
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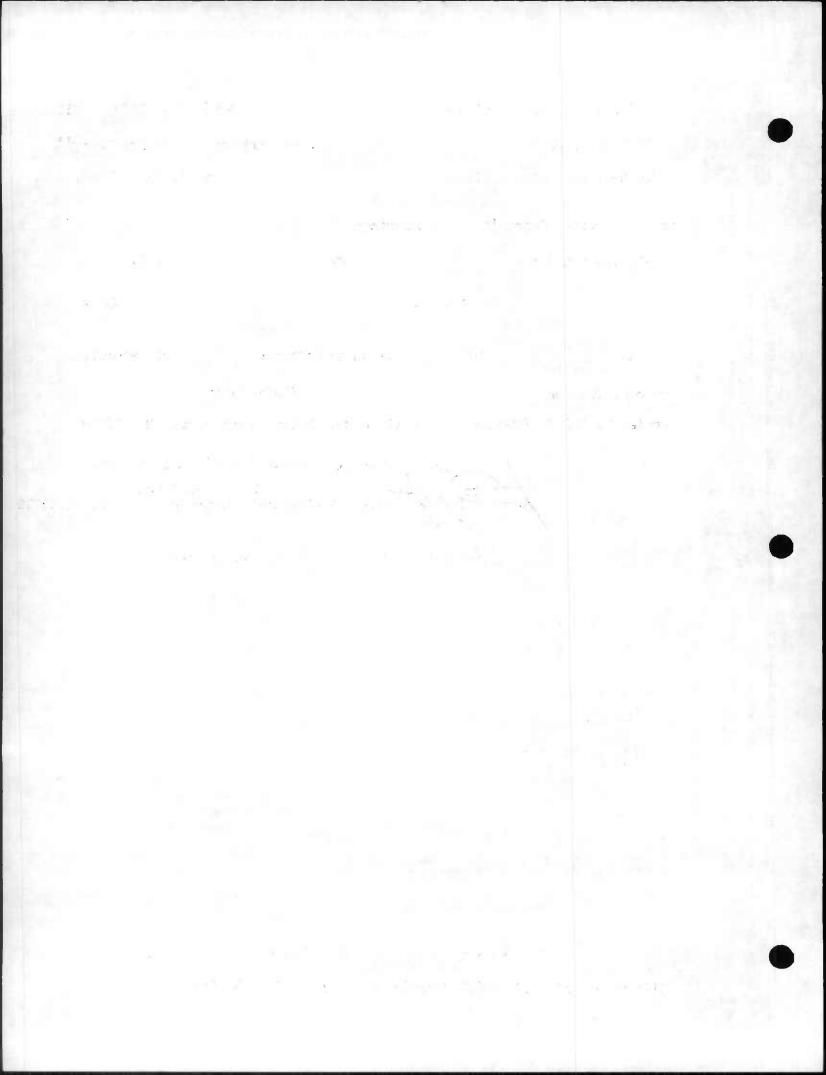
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and Mental Hygiene. Is marked other than "natural", or itams 23a or 28a-f show Example and the count, the Medical Evanture must be notified as a function of the count, the Medical Evanture must be notified as a function. To Be Completed by Funeral Director	4e Fecility Neme (If not institution, give Sacred Heart Ho 5. Social Security Number 6. Sc 116-30-4671 Usuel Residence of Decedent 10a. Stete 10b. County	Fiscina a street end number) ome, Inc. ex OME OME OME OME OME OME OME OME OME OME		Location Location LSV1116 10f. Zip	1 Year Deys	Hyati	Mont Apr or Location of tsville	il 14 Death	ar)	yeer 9 5: of Deeth e Georg 9. Birthplece Country) Penns	Time of Deeth 50 am Ge's (Stete or Foreig ylvania
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Haaitt em 27 thar t							r Rurel Route I				e)
1 6 2	Jo-Ann Fiscina - Dau		V 2 I			Court,	Rockvi				0852
nt: If Its	20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐		ob. Place of Dis cemetery, ci	rematory or ot	her plea	ce)	Date	20c.	Location -	City or Town,	State
ant:	4 ☐ Donetion 5 ☐ Other (Specify		St. Ann	n's Cem	nete	ry	04/19/	99 H	ornel:	1, New	York
Department of Health Important: If Item 27 any Injury or other trongs.	21. Signeture of Funerel Service Licen	see	(s Fu	neral H	Home, P			100	20701
	23a. Pert1. Enter the diseese, or compshock, or heart failure. List only	Teise					venue,		SVILL		20781 proximete ervel Between
kaminer ja	disease or condition resulting in death)	e. Due	espira to (or es e cons Quan	sequence of):	Ede	ema				D)ay 5
e ettending physician and od for use as the burial-transit sician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events	C	to (or es e cons	sequérice of):							
nding physicials as the but as as the but and an article.	resulting in deeth) Lest	d	to (or es e cons	equenca of):							
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2 s b							24a.	Was en eu performed	utopsy ?	eveileb	outopsy finding le prior to stion of cause h?
page 2								1 🗆 Yes	2 No	1 □ Ye	s 2 No
actor, p	25. Was case referred to medical					26. Plece of	Death (Check	only one)			
o dire	examiner? 1 ☐ Yes 2 No	Hospitel: 1 ☐ inpatient	2 ☐ ER/Outpet	ient 3 DO	A Oth	000	ng Home 5□		a 6 □Othe	er (Specify)	
octor: After this by the funerel	27. Manner of Deeth ↑ Neturel 5 □ Pending 2 □ Accident investigation	28e. Date of Injury (Month, Day Ye	ar) 28b. Time Injury	of 28	Bc. injur Wor		1		njury occurr		
Director of in by th	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - building, etc. (S	At home, farm, pecify)	street, factory	, office			tion (Street or Town, St		er or Rural Ro	ute Number,
within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral Medical Certification: 7		ysician: To the best of my niner: On the besis of exa and manner stated.									
rothin Somp	29b. Signeture end title of certifier			290	Licens	e number		29d.	Date signed	d (Month, Dey,	Yeer)
	> Sta				D	3793	4	A	pril	14, 199	99
7	30. Neme end eddress of person who	completed sauce of don't	/Item 22a\ /T	o Print\	9	,,,,	/	**		_ , ,	
[5]	So. Neme end eduless of person who o		7500								
State	C 7 - C	oxlio MI)		(00000	2 /	1.1.	D G		.14 ,		70



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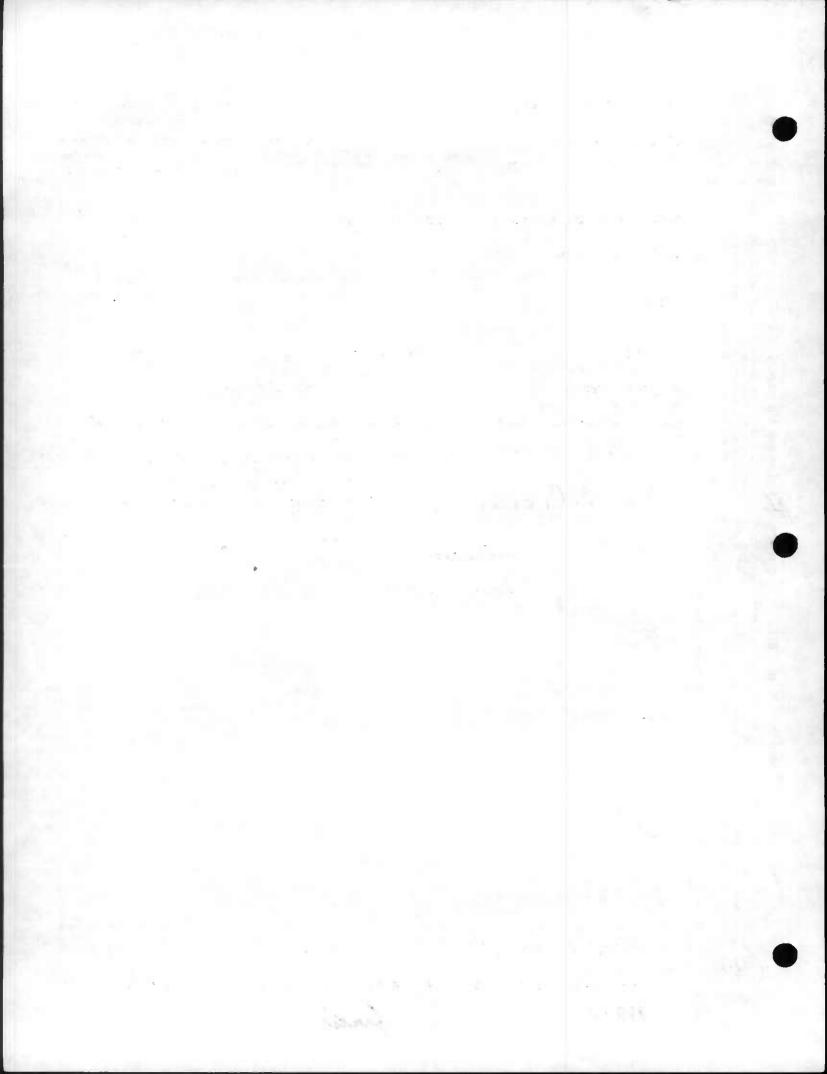
Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1999 Vincent Charles Grinder April 18, 6:38PM /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Camp Springs Prince George's 6211 Trueman Drive If Under 1 Year 5. Sociel Security Number 7. Age (In vrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Birthplace (Stete or Foreign Country) **Funeral** 1☐M 2□F Months Deys Hours Min Yrs. Director 578-20-7740 Usuel Residence of Deceden July 21, 1923 Wash. D.C. 75 the Maryland 10a, Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits r is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Prince George's Camp Springs 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pegas 1 and 2 should be filed within 72 hours eftar death a Department of Health and Mentel Hygiana. Important: If Item 27 is marked other than "nahural" any Injury or other transmitted. U.S.A. Funeral 6211 Trueman Drive 20748 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian 11 Maritel Status Black, White, etc. 1 Types 2 No
If Yes, Give
Year or Dates: 1942-46 1 Never Married 2 Married 1□ Yes 2□No Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Glass Manufacturer Self employed N/A18. Mother's Name (First, Middle, Meiden Surname) 17. Fether's Neme (First, Middle, Last) Be 2 Flora Ficco Owen M. Grinder 19a. informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Avhlee M. Grinder/Spouse 6211 Trueman Drive Camp Springs, Md. 20748 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Melhod of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) April 22,1999 Clinton, Md. Lee Crematorium 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Lee Funeral Home, INC. 6633 Old Alexandria Ferry Rd. Clinton, Md. 20735 not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 23a. Pert1. Enter the disease, or complications that caused shock, or heert feilure. List only one ceuse on each Approximete Intervel Between Onset end Deeth **Physician** ronic obstructive pulmonary disess /Medicai Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner sician and buriel-transit certificate be executed Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): physician a Box 68760. Physician/Medical Due to (or es e consequence of) that the deeth Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 3 Probably 4 Unknown 1 Yes 2 No disorder Records, þ law requires 24b. Were autopsy findings eveilable prior to 24e. Was en eutopsy performed? Completed peen ty percarbig completion of ceuse of deeth? After this certificeta hes The 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital Attending Physician: funarei director, Be 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Certification: To 28e. Date of Injury (Month, Day Year) 28c. injury et Work? 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of Natural 5 Pending daath. 1 Yes 2 No investigation 2 Accident al or Attend s after daath il Director: / 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) à 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier K Certifying Phyeician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end manner as stated. edical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 60 20 D0047928 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 10+1 Lila Bahadoori, M.D. 10301 Georgia Ave. # 304 Silver Spring, Md. 32. Registrar's Signeture State Geneva APR 20 1999 Registrar



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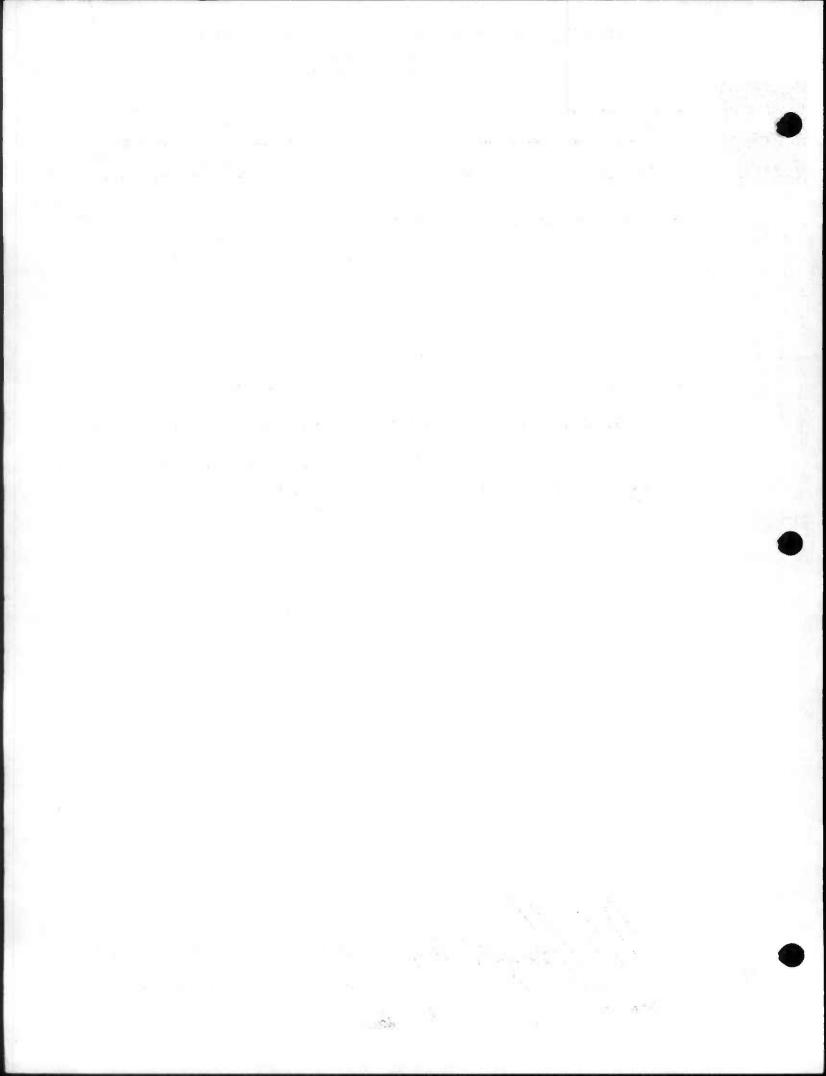
State of Maryland / Department of Health and Mental Hygiene

ysician	1. Decedent's Name (First, M.	iddle, Last)			tificate of		2. Date of Dea	ith	3. Tin	ne of Dealh
-	Gladys Thoma						Month April	Day 14, 19	Year 99 8	:00 pm
Medical kaminer	4a Facility Name (If not Institu		ber)			4b. City, Town, or L				voo Piii
ammei	6501 44th Ave	nue				Universi	v Park	Princ	e George	s
eral	5. Social Sacurity Number		. Aga (In yrs. las	t birthday)	If Under 1 Year				9. Birthplace (SI Country)	
П	236-22-5674 Usual Residence of Decedent	1□ M 2\(\text{\text{\$\tex{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\}\$\}}}}\$}}}}}}}}}}}}}}}}}}}}}}}}}}}}	76	Yrs.	Months Days	Hours Min.	8. Dete of Birth (Month, Day Nov. 1	2, 1922	Virginia	a
Ļ	10a. Stete 10b. Cou			Town or Loc					100	de City Limits Yes 2 □ No
cto	Maryland Prin	ce George's	Univ	ersit	y Park					105 2 100
Director	10e. Street and Number 6501 44th Ave				10f. Zip Code 20782			10g. Citizen of V U . S . A .	Vhat Country?	
erai	1t. Marital Stetus		ent Ever in U.S.	13 V		lispanic Origin? (St			e - American India	an
Completed by Funeral	1 Never Married 2 Never Marrie	Armed Ford Armed Ford 1 Yes 2	es? !∭No		i Yes, specify Cuba I □ Yas 2 🗓 No	lispenic Origin? (Span, Mexican, Puerti Specify:	Rican, etc.)	Blac	k, White, etc. : White	
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mple	Elamantary/Secondary (0-1		4or 5+)			during most of world)		0 11		
ပိ	1.2 17. Father's Name (First, Midd	do lest)		Homem	laker	18. Mother's Nan		Own Hom		
Be	Benjamin Thom					Blanche		maraon carrian	,	
To	19a. Intermant's Name/Raiati			19b. Mailin	a Addrass (Street	and Number or Ru		r. City or Town.	State, Zip Code)	
	Beth C. Crawf	ord - Daught	er	4409	40th Str	eet, Bre	ntwood,	Marvlan	d 20722	
	20a. Method of Disposition		20b. Pia		sition (Name of natory or other pla		Dete		City or Town, Sta	ta
- Albert	1 ☐ Burial 2 ☐ Crematic		ate		tan Crem		4/16/99	Alexand	ria, Vir	ginia
	21. Signature of Funeral Sarv	ice Licensae		22	. Name and Addre	ss of Facility			•	
	NW.B	Gais				uneral Ho imore Ave			10 MD 2	0781
	23a. Part1. Enter the disease	, or complications thet ca List only one cause on ea	used the deeth.						Approx	kimate bi Between
ın	Shock, of Heelt tailule.	List offly one cause on ea	or me.							and Death
al .	Immediate Cause (Finei disease or condition resulting in daath)	Hepat	cic Coma	1					2 Da	vs
r	resulting in daath)	a	Due to (or a		uence ot):					
ine		Panci	ceatic (Cancer					9 Mo	nths
Examiner	Sequantially tist conditions, if any, leading to immediate		Due to (or a	is a conseq	uance of):					
al E	Sequantially fist conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or injury that initiated events	c	2016							
edical	resulting in daath) Last		Due to (or a	s a consequ	uence ot):				1	
2		d								
sicia	Pert II. Other significant cond	ditions contributing to dea	th but not result	ing in the ur	nderlying cause giv	ven in Part I.	23b. Dld 1	obacco use co	ntribute to the ca	use of death?
by Physician/M	Breast Cance						10	Yes 2 No	3 Probably	4 Unknown
by	Dreast Cance	L			-					
ted							24a. Was perfo	an autopsy rmed?	24b. Were auto available p	prior to
Completed									of death?	n of cause
Con							1 🗆 1	res 2∑ No	1 □ Yes	2□ No
Be	25. Was case raferrad to med axaminar?						th (Check only o			
2	1 ☐ Yas 2 ☒ No		patient 2 El			4 Nursing H	ome 5 D Resid			
Certification:	27. Mannar of Death 1 ☐ Maturai 5 ☐ Per	nding 28a. Data of (Month)	Day Year)	8b. Time of Injury	Wo	rk? Yes 2 □ No	Zou. Describe !	now injury occur	100	
fica	3 ☐ Suicide 6 ☐ Cou	uld not be 28a. Piace of	t Injury - At hom	a, tarm. stre	eet, tactory, office	20,00			per or Rural Route	Number,
ert	4 ☐ Homicida det	arminad 28a. Place of building	g, atc. (Spacify)	,, σειτ			City or Tox			
edicai C		fying Physician: To tha b cal Examiner: On the bas and manne	is of examinatio							use(s)
Medical Certification: 7	29b. Signature and this of cert	tifier	0		29c. Licens	se nu <i>m</i> ber		29d. Date signe	d (Month, Day, Ye	ear)
Me		0 1	//					1.1	1	
M M	1 Som	1 lalu			D372	36		4/15	199	
Me	30. Name and address of pers	son who dompleted cause	ot death (Item 2	3a) (Type, I		36		4/15	199	



State of Maryland / Department of Health and Mental Hygiene 9

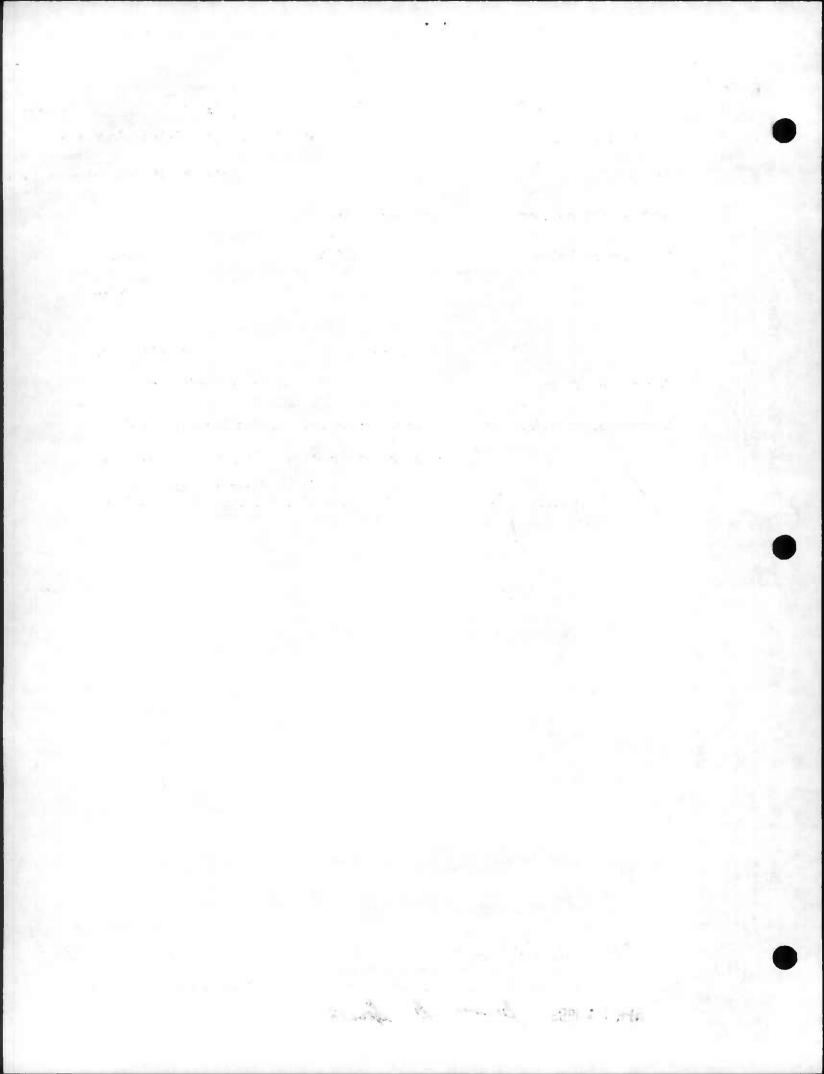
						Cert	ificate of		R	eg. No.		201 190	2
	Physici	an	1. Decedent's Neme (First, Middle, Last)						2. Dete of Dee	th Dev	Yeer	3. Time of	Deeth
	/Medi		Mary Helen Gill						April	12, 19		6:03	} pm
1	Examir		4a. Fecility Neme (If not institution, give s					4b. City, Town, or	Location of Death	4c. County	of Death		
			Washington Advent	ist Hospit	tal			Takoma l		Montgo	omery		
	Funeral Director		103-03-7737	44 - CX -	(In yrs. lest b		Months Deys		(Month, Dev	Year) 9, 1915	9. Birthple Count Penns	ece <i>(State d</i> lry) sylvan	or Foreign 11a
	pue		Usuei Residence of Decedent 10e. Stete 10b. County		10c. City, To	wn or Loca	ution				10	d. Inside Ci	its I imite
	/enyte	5	Maryland Prince Ge	orgolo	Hyatt						10	1 ☑ Yes	
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	with with	ă	1836 Longford Driv				20782				whet Count	ry r	
	eeth	era		12. Wes Decedent E	ver in U.S.	13 W		Hispanic Orlain? /9		U.S.A.	e - Americe	en Indien	
21215-0020	iges 1 and 2 should be filed within 72 hours efter deeth with the Meryland to f Heelih and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner roust be notified at	by Funeral	1 □ Never Merried 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Yeer or Detes:			/es, specify Cul	Hispenic Origin? (S ben, Mexicen, Puer Specify:	to Ricen, etc.)	Bied	k, White, e	etc.	
5-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation (atad)	16	a. Deceder	nt's Usuei Occu	ipation during most of wo	rking	16b. Kind of Bi	usiness/Ind	ustry	
21	e. an	npie	Elementary/Secondery (0-12)	College (1-4or 5-		life. DC	NOT use retir	ed)	rking				
	od wi	Son	10			mema	ker			Own Hon	ne		
pu	al Hy t oth	Be	17. Fether's Neme (First, Middle, Last)					18. Mother's Ne	me (First, Middle, I	Malden Suman	ne)		
yla	Ment Ment	2	John Lindsay					Margret	a Stephe	ns			
Maryland	and and is ma		19e. Informent's Name/Reletionship (Ty)	*				et end Number or R					
	Heelth Heelth em 27 i		Michael P. Gill -	Son	-			Road, Bla					
ore	of He		20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Re	emovel from State	20b. Plece cemen	of Disposit e <i>ry, cre</i> me	tion (Neme of tory or other pl	ece)	Dete	20c. Location -	City or Tov	vn, Stete	
E	Peg ment ant: I		4 ☐ Donetion 5 ☐ Other (Specify)	antover from Stelle	Fort	Linc	oln Cem	etery	04/15/99	Brentwo	ood, N	Maryla	and
Baltimore,	permit. Peges I Depertment of H Important: If its any injury or ot		21. Signeture of Funerei Service License	£ 0)	G		Funeral H				m 003	
-	_		23a. Pert1. Enter the disease, or complications, or heart feiture. List only on	cetions thet caused	the deeth. Do	not enter	the mode of dy	timore Av	c or respiretory err	attsvij est.		Approximet Intervel Bet	
	Physician		shock, or heert feiture. List only on	e ceuse on eech line	9.							Intervel Bet Onset and I	ween Death
и	/Medicai		Immediate Ceuse (Finel disease or condition	1 a + h = a + +	o Date	. عاد ما م							
п	Examiner		resulting in death)	Asthmati	Oue to (or es e						13	B Days	-
		ner			700 10 101 00 0	oonsoque	onoo or).				1		
	tificete be executed ig physician and es the buriel-transit	Examiner	Sequentially list conditions	. —	Due to (or es e	conseque	ence of):						
o,	an an		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury										
68760,	ysici	cal	thet Initiated events resulting In deeth) Lest	D	ue to (or es e	conseque	ince of):						
	E 00	Med									i		
Вох	death cert e ettending ed for use	an	d	•									
	dea he et ed fo	sici	Pert II. Other eignificant conditione con	tributing to deeth but	not resulting	in the und	erlying cause g	iven In Pert I.	23b. Did to	bacco use co	ntribute to	the cause	of death?
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Ś	es that igned to be det	by	Adenosquamous Care	.IIIOma OI	ratuti	u GI	anu						
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Vital	Physician: The this certificate rel director, pag	Be	25. Wes case referred to medical exeminer?					26. Place of De	eth (Check only on	e)			
of \	physic this co	2	1 ☐ Yes 2 🛣 No	ospitel: 1 🗓 Inpatien	t 2 ER/C	Outpatient	3□ DOA O	ther: 4 Nursing I	dome 5 ☐ Reside	ence 6 Oth	er (Specify))	
		:uo	27. Manner of Death 1 Naturel 5 □ Pending	28e. Dete of Injury (Month, Dey	Year) 28b.	Time of tnjury	28c. Inju	ury et ork?	28d. Describe ho	w injury occur	red		
0	Attending ir death. actor: After by the fune	ati	2 Accident investigation				M 1	Yes 2 No					
Division	or Attend efter death Director: A	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	y - At home, t (Specify)	arm, stree	t, factory, office		28f. Location (Si City or Town		er or Rural	Route Num	ber,
	urs e urs e rai D		v	1									
	Hosp 24 ho Fune Hely f	edicai	29a. Certifier 1 Certifying Physical Examinone)	clan. To the best of	exeminetion e	e, deeth o nd/or inves	ccurred et the t stigation, in my	ime, date end piece opinion, deeth occu	e, end due to the ca arred et the time, d	ause(s) end me ate end plece,	enner es ste end due to	ited. the ceuse(s	;)
	To the Hospital or I within 24 hours efter To the Funeral Director Completely filled in L	Med	29b. Signature and tyle of Josepher	and manner state	ed.		29r Licen	se number	2	9d. Date signe	d (Month F	lev Voor	
	F 3 F 8		1/1/1/1/1/	1.10-11	1 h	1							
	12		1/1/1/100	4416/14	111	/	D087	04		April 1	3, 19	99	
1	5)		30. Name and address of person who con	11				h D - 1	0 :	1	-	1 00=	7.0
1	-01	•	Thomas A. Bensinge	M.D.		reenv	vay Cen	ter Drive	, Greenb	elt, Ma	rylan	.d 207	/0
	Sta Registr	ie ar	31. Dete fine twenth, Day, Year) 4 1995	A PART TO A STATE OF THE PARTY			p:						



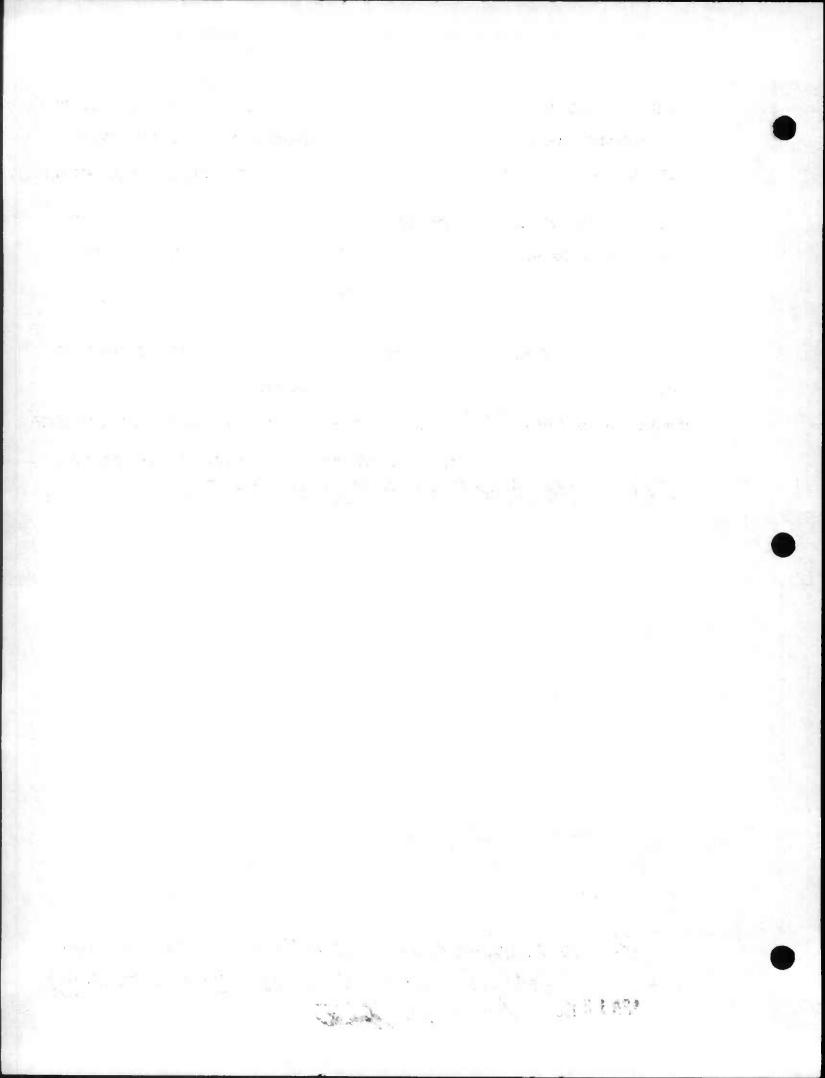
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Tima of Death 2. Data of Death Month **Physician** Glick Bertrum Dennis 8:02 A.M. 1999 April 12 /Medical 4a Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 2204 Jerome Drive Fort Washington If Undar 24 Hrs. Hours | Min. 5. Social Security Number If Undar 1 Yaar Birthplace (Stata or Foraign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months 11XM 2□ F Days Director April 24, 1945 Washington, D.C. 577-62-7671 tha Maryland 10c. City. Town or Location 10a Stata 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, tre Medical Examiner must be notified at 1 ☐ Yas 2 No Maryland Prince George's Fort Washington Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 20744 U.S.A. 2204 Jerome Drive Funeral permit. Pages 1 and 2 should be filed within 72 hours aftar death Department of Heelth and Mantal Hygiana. Important: If item 27 is marked other than "natural", or itema 23, any injury or other traumatic event, tre Modical Expressionals. 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Evar in U,S.
Arroed Forces?
1 ☐ Yas 2 ☐ No Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 11 Maritel Stetus XXNever Merried 2 Married Specify:White Baltimore, Maryland 21215-0020 If Yas, Giva Year or Datas: Unknown 1 Yas 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Worker Retail Store 18. Mother's Neme (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Bertrum S. Glick Lenore M. McCormick 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Routa Number, City or Town, Stata, Zip Code) Bertrum S. Glick/Father 2204 Jerome Dr. Ft. Washington, MD.20744 20e. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stete 1 A Burial 2 Cramation 3 Ramoval from Stata 4/15/99 Resurrection Cemetery Clinton, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility George P. Kalas Funeral Home, P.A. 21. Signature Funeral Service Licensea also 6160 Oxon Hill Rd. Oxon Hill, MD 20745 art1. Entar the disease, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximeta Intarval Batween Onsat and Death **Physician** Immediate Ceusa (Finel diseasa or condition resulting in deeth) /wedicar CAROLONY CJAKA; Examiner Examiner MyocARAixi attending physician end for use es the buriel-transit that the death cartificeta be axecuted Sequantially list conditions, if any, leading to immadiata ceusa. Enter Underlying Causa (Disaasa or injury that initiated avents rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings eveilable prior to 24a. Was an autopsy performed? Completed complation of causa of deeth? hes 2 No 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attanding Physician: 24 hours ofter death. Funeral Director: After this cartific funaral director, 25. Was cesa rafarrad to medical examiner? Be 26. Piece of Deeth (Check only one) Othar: 4 Nursing Homa 5 X Rasidance 8 Othar (Specify) Yes 2 No 27. Mannar of Daath P 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Naturel 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be determined 28f. Location (Straat and Numbar or Rural Route Number, City or Town, Stata) 28a. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) illed in by 4 I Homicida 24 hours 1 Certifying Phyaician: To the bast of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. To the Hosp within 24 hou To the Funer complately fil 29a. Cartifian Medical (Check only one) 29b. Signatura and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 30. Neme and addrass of person who completed ceusa of death (Itam 23a) (Type, Print) LIVINGSOON RN. FE. WASHINGTON Md. 20744 NEDZBALA. MA 11701 31. Data filed (Month, Day, Year) APR 1 4 1999 32. Registrar's Signatura State Registrar



			State of Maryla		tificate of		Re	g. No.	1 4	143
Physic	ian	Decedant's Nama (First, Middle, Last)				2. Data of Deat Month	Day	Yeer	3. Time for th
/Medi		THEIMA A. GAINEY 4e. Facility Nama (If not institution, giva	street and number)			4b. City, Town, or	APRIL Location of Death	4c. County		10:30 AM
Exami	ner	INDEPENDENCE COUL				HYATTSVI			E GEO	RGES
Funeral	П	Social Security Number 6. Sa		rs. iast birthdey)	If Under 1 Year Months Deys	If Under 24 Hrs Hours Min.	8. Date of Birth	Veerl	9. Birthplac	ce (Stete or Foreign
Director		5/8-48-4960	103 ≥ 103	Yrs.	Worth's Deys	110013	8. Date of Birth (Month, Dey, JUNE 21	, 1895	WASHI	VGTON, DC
and		Usual Rasidance of Decedent 10a. Stete 10b. County	10c.	City, Town or Lo	cation				100	I. Inside City Limits
Many H sh	to	MARYLAND ANNE ARU	VDEL C	ROFTON						1 Yes 2 No
r 28a	Director	10e. Street and Number		1.02 2011	10f. Zip Coda		10	Og. Citizen of \	What Country	n
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within 72 hours efter death with the Maryland ene. than "nature!", or items 23e or 28e-f show the Medical Examiner must be notified at	by Funeral	11. Meritel Stetus 1 Never Married 2 Married	12. Was Dacedent Evar In Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva	1	Vas Decedent of I f Yas, specify Cub	Hispenic Orlgin? (Seen, Mexican, Puart Specify:	pecify Yes or No- to Ricen, atc.)	Blee	ce - American ck, White, etc	o
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		ESTHERMAGRUDER / N. 20e. Method of Disposition	IECE-IN-LAW	. Place of Dispo	sition (Nema of		EARFIELD Dete 2	PEINING	-	
Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temovel from State	cemetery, cren	netory or other ple	,	4/10/99			
permit. Pag Depertment Important: If eny Injury o		21. Specify of Funeral Service Ligens	-		CREMATO Name and Addre				, MAR	TIMIND
permit. Pages 1 at Depertment of Hee Important: if item: eny injury or other once.		Maia C The	note forther				OME, P.A		a MD	20640
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cete be executed physicien and the buriel-transit	il Examiner	resulting In deeth) Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury).	o (or as a conseq	uence of):		,,,,,,			1
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i or Attending I efter deeth. Director: After d in by the funer	tion	1 Neturel 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	28c. Inju Wo	rk? Yes 2 □ No	Log. Dogwide no	w many occur	100	
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To the Hospital or within 24 hours efte To the Funeral Dir completely filled in	edical	(Check only 2 Medical Examin	ician: To the best of my k	nowledge, deeth nation end/or Inv	occurred et the ti	me, dete end plece	, end due to the ca	use(s) end me	enner es stat	ed. ne ceuse(s)
within 2. To the P	Med	one) 29b. Signature end title of certifiar	end manner steted.		29c. Licens					
T × F 8		255. Signature end little of Certifier	· Onla	11.7				d. Date signe		
(6)		30. Name end eddress of person who co	mpleted cadse of deeth (II	om 02a) (Time 1	2 days	100	1	IKIL	7 19	44
		PALAD	EVORE!	MD 42	03 20	eessbu	my Rd 1	4460	DV.1/	20281
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death 2. Deta of Death Day Yaai **Physician** Jean Ross Holt April 14 1999 9:30am /Medical 4e Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Sunrise Assisted Living Columbia Howard If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Days 1 M 2 XF Months 712-01-2829 Director Dec 24, 1921 Georgia Usual Rasidance of Decedent the Maryland 10a. Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at 1 ☐ Yas 2 € No Directo Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6500 Freetown Road 21044 United States death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, atc. 11 Meritel Status Pages 1 and 2 should be filed within 72 hours after on not of Health and Mental Hygiana. Int: If Item 27 is marked other than "natural", or Ite 1 □ Nevar Married 2 □ Married Saltimore, Marviand 21215-0020 1 Yes 2 No Specify: P 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fethar's Neme (First, Middle, Last) Be Charles C. Ross Bertha Coffee 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health er Important: if Nem 27 is any Injury or other treu Nancy McCloskey/Daughter 8535 Autumn Rust Road Ellicott City, MD 21043 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t⊠ Buriel 2 ☐ Cremetion 3 ☑ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 4-17-99 Athens, Georgia Oconee Hill Cemetery Harry H. Witzke's Family Funeral Home, Inc. 21. Signeture of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 0 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervat Batwe Onset end Death **Physician** Immediete Ceuse (Finel disease or condition rasulting in deeth) /Medical Examine Dua to (or es a consequence of): Examiner physician and the burial-transit The lew requires that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Diseese or injury that initieted events rasulting in deeth) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 88 ò Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. the 23b. Did tobacco use contribute to the cause of death? signed by t t ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown dene à 24b. Wera autopsy findings evailable prior to complation of cause of daath? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physicien: director 25. Wes case rafarred to medical examinar? 8 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After this 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 1 X Naturel 5 Pending 124 hours efter death.

Permeral Director: A pletely filled in by the fi 1 TYes 2 No death. investigation 2 ☐ Accident 6 Could not be detarmined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier edical 🖾 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the cause(s) end manner es stated. To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar JA COB

31. Dete filed (Month, Day, Year)

DHMH 16 Rev 6/95

Med GOUD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6

atixent

32. Registrags Signature

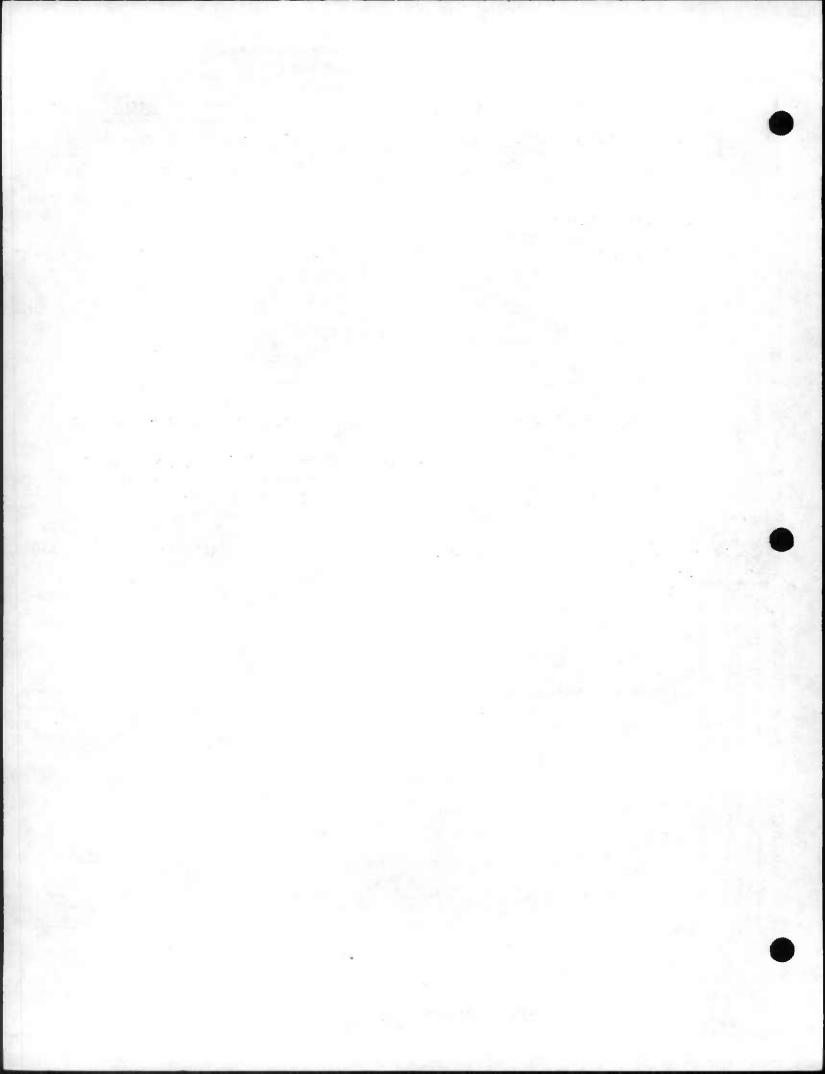
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April 15, 1999

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State of Maryland / Department of Health and Mental Hygiene

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and *		5. Sociel Security Number 8. 217 07 4908 Usuel Residence of Decedent	ARTHUR OF THE	9a <i>(I</i> n <i>yrs. la</i> 79	rst birthdey) Yrs.	If Under 1 Y Months Do	aar If Under 24 Hr. ays Hours Mir		th by, Year) 1920	9. Birthplece Country) Cumbe	e (Stete or Foreign rland, M
~ 2 =		10a. State 10b. County		10c. City,	Town or Loca	ation				10d.	Inside City Limits
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er deeth with th Rems 23a or 24 ner must be no	Funeral Director	10e. Street and Number 3610 Chesapeake				10f. Zip Co. 207	32		10g. Citizen of V	SA	
s 1 and 2 should be filed within 72 hours efter deeth with the Meryland if Health and Mental Hygiena. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	by	11. Merital Status 1 Navar Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedant Armed Forces? 1 X Yas 2 If Yes, Give Yaer or Detas:	No			of Hispanlc Origin? (Cuben, Mexican, Pue No Specify:	Specify Yes or No rto Rican, atc.)	Specify	e · American I ok, White, etc. · White	
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2 shou end M is mar	-	19e. Informent'e Neme/Reletionship	(Type, Print)		19b. Meiling	Address (St	reat end Number or F	Rural Route Numb	er, City or Town,	State, Zip Co	de)
D E Z		Hazel M. Hardy /	wife				0 above				
permit. Pages 1 at Department of Hea Important: if Item 3 any Injury or other 900.00.		20e. Method of Disposition 1 Burial 2 □ Cremetion 3 4 □ Donetion 5 □ Other (Special Contents)		car	ca of Disposi metery, creme Linco	etory or other	piece)	Date 4-23-99	20c. Location - Brentwo		
Depar Impor any In		21. Signetura of Funeral Service Lica	Koss				ddress of Fecility Funeral Ho	ome, P.A	., Owin	gs, MD	20736
Physician /Medical Examiner		23a. Pert1. Enter the disease, or conshock, or heart feilure. List only Immadlata Ceuse (Final disease or condition	o e cluse on eech II			r the mode of	dying, such es cardie	ac or raspiratory a	rrest,	Ap Inte On	proximeta ervel Between eset and Death
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Page H	Соп							10	Yes 2 No	1 □ Ye	es 2 No
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State of Maryland / Department of Health and Mental Hygiene

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þ	3 ☑ Widowed 4 ☐ Dive	orced	If Yes, G Yaar or	Dates:		1□ Yes 2	SIM NO	Specify:			Spec	ity: B1	ack
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death MARGARET NAOMI HURT 1999 APRIL 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 1 1 F 579-38-2958 Yrs. 70 Nov. 5, 1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5808 - 42nd Avenue, Apt #416 20781 14. Raca - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 Never Married 2 K Married 1 Tyes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Government 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) John Borden Anderson Isabelle McCloud 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Barry C. Hawkins/Son 501 - 53rd Place, Hyattsville, Maryland 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 04/12 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 1999 Washington, D.C. 22. Name end Address of Facility 21. Signeture of Funeral Service Licenses J. B. JENKINS FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? completion of cause of death? 20 No 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) 1 Yes 2 No 32 DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient

Physician /Medical **Examiner**

Physician

/Medical

Examiner

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permit. Pages 1 and 2 should be filed within 72 hours efter death with the Merylen Depertment of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Exemples must be notified at 9000s.

Examiner The lew requires that the deeth certificete be executed physician and the buriel-trensit Physician/Medical ettending p signed by the e should I Completed

Box 68760.

P.O.

his certificate hes bil director, page 2 sl ei or Attending Physician: T s efter death. Il Director: Atter this certificat ed in by the funeral director, p

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Division of Vital Records. Certification: To the Hospital or within 24 hours eft To the Funeral DI completely filled in Medical

> State Registrar

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 28e. Dete of fnjury (Month, Day Year) 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) 30. Name and eddress of person

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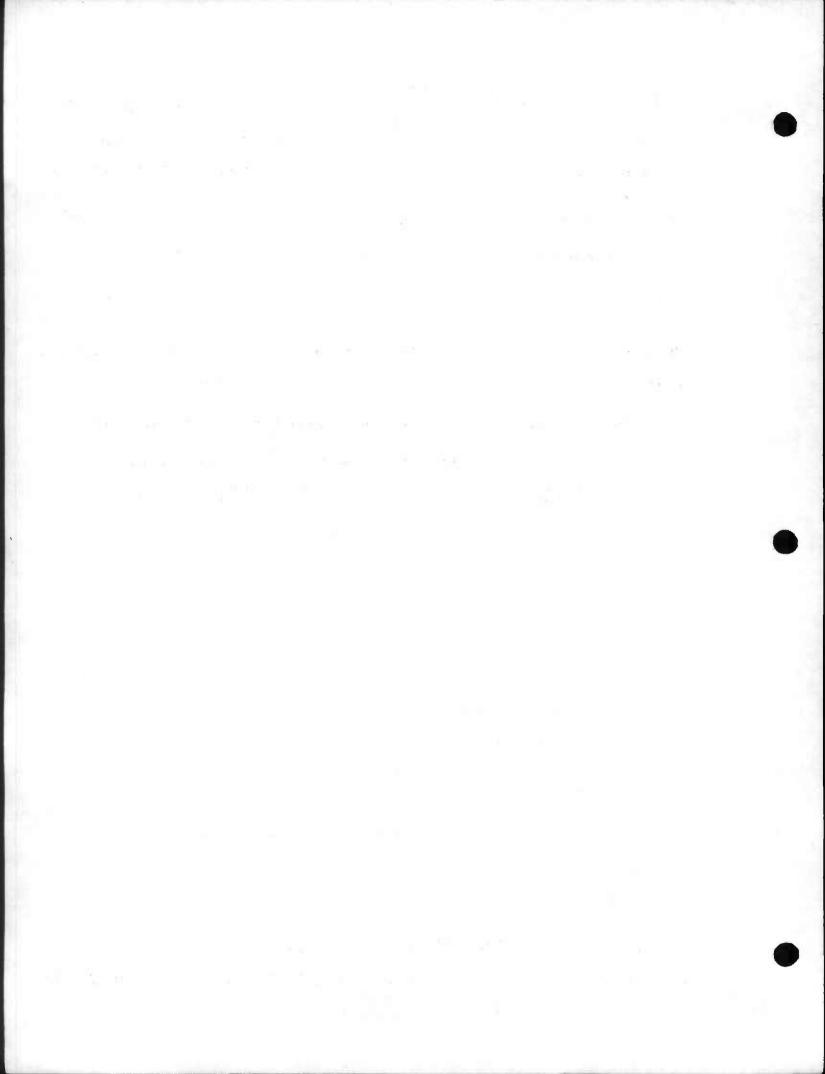
1 2 1999 37: Registrer's Signeture 31. Date filed (Month)

Corporate Blud. Rockville

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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	or 28	Jirec	10a. Straat and Number		10f. Zip Code		10g. Citizan of Who	at Country?
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Baltimore,	ges 1 en t of Heal if item 2 or other		20a. Mathod of Disposition 1 ☒ Kurial 2 ☐ Cramation 3 ☐ Removel from Sta	camata	of Disposition (Nama of ary, cramatory or other pleca)	Data	20c. Location - Cit	ty or Town, State
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Bal	permit. Peges 1 Department of H Important: If Itel eny injury or ott		21. Signature of Funaral Sarvica Licansea		22. Nama and Addrass of Facility Donaldson Funeral 313 Talbott Avenu			nd 20707
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Dacedant's Nema (First, Middle, Last) 2. Deta of Death 3 Time of Deeth Month Dey **Physician** GERTRUDE MAY **ISEMANN** April 12:40 pm /Medical 14 1999 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Gloucester Street Anne Arundel Churchton If Undar 1 Yaar | If Undar 24 Hrs. 5. Sociei Security Number 7. Aga (In yrs. last birthdey) Birthplaca (State or Foreign Country) 8. Dete of Birth (Month, Dev. Year) **Funeral** 1□ M 2♥ F Months Days Hours Min Yrs. 578 40 7291 Director 67 Sep. 16,1931 Wash., D.C. Usual Residence of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 ☑ No Director Anne Arundel Churchton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5529 Gloucester Street 20733 USA Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Race - American Indian, Black, White, etc. 11. Mantal Stetus 12. Was Decedant Evar in U,S. Armed Forces?

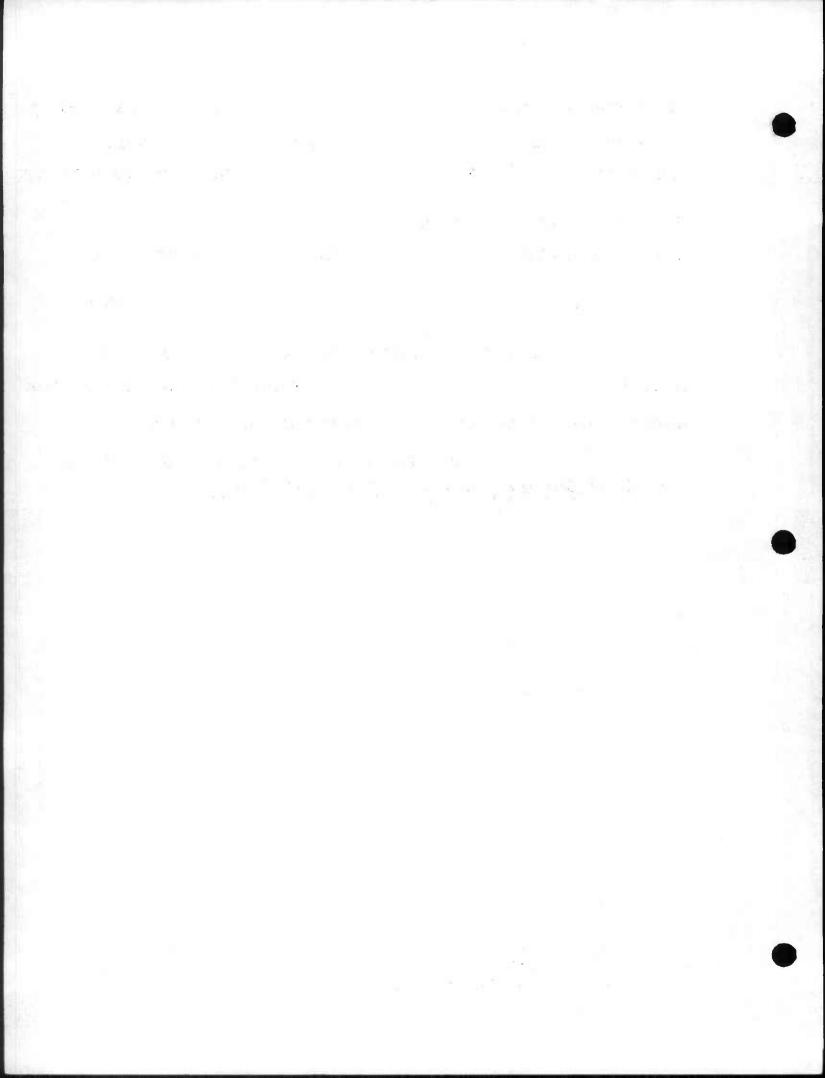
1 Yas 2 No ff Yas, Give Yaar or Detes: 1 ☐ Nevar Married 2K Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meidan Surnema) Be William E. Durity Dorothy Reid 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Paul E. Isemann - husband 5529 Gloucester St., Churchton, MD 20b. Plece of Disposition (Neme of cematary, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Burlel 2 ☑ Cremetion 3 ☐ Removei from State 4 ☐ Donation 5 ☐ Other (Specify) 4-15-99 Alexandria, VA Metropolitan Crematory 21. Signeture of Funeral Service License 22. Neme and Address of Facility Rausch Funeral Home, P.A., Owings, MD Mulan Ross 20736 23a. Pert1. Entar the disease, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or raspiratory arrast, shock, or heer feiture. List only one causa on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, physiclen s the burie Physician/Medical Due to (or as a consequence of). USB BS signed by the atter Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by should Completed 24a. Was an autopsy 24b. Were autopsy findings peen aveilable prior to completion of cause of deeth? page 2 has certificata 1 Yes 2 No 1 Yes 2 No funaral director. Be 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Certification: To 1 Yes 2 No Aftar this 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 5 Pending investigetion 1 Neturai 24 hours after death. 1 Yes 2 No 2 Accidant 5 6 Could not ba determined within 24 hours after dea To the Funeral Director completely filled in by th 3 Suicide 28e. Plece of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 4 Homicide Hospital 29a. Certifiar 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, deta and place, and due to the cause(s) and manner es steted. Medical (Check only 2 Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, deeth occurred at the time, date and pleca, end due to the cause(s) and manner steted. 295. Signature and title 6, con 29c. License number 29d. Date signed (Month, Day, Year) au epleted cause of deeth (Item 23a) (Type, Print) 6008611 31. Dete filed (Month, Dey, Year) 32. Registrade Signeture State 1999 5 Registrar

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State of Maryland / Department of Health and Mental Hygiene

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10e. Street end Nu		JOHERT			10f. Zip Code		10	0g. Citizen of	What Cou	into/?
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11. Marital Status	OLL CI		edent Ever in U.S	13. V			pecify Yes or No-			ican Indian,
1X Never Mari	ried 2□ Mar	Armed F	orces?	If	Yes, specify Cu	Hispenic Origin? (S ban, Mexican, Puert	o Rican, etc.)		ck, White	, etc.
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Division of Vital Records, P.O. Box 68760,

The law requires that the deeth certificate be executed

To the Hospital or Attending Physician: The law requires that the deeth within 24 hours effect death.

Within 24 hours effect death.

The Funeral Director, Affect his certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for Medicai Certification: To

State Registrar

31. Date filed (Month, Day, Year) APR 1 2 1999

Directo

Be Completed by Funeral

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Examiner

Physician/Medical

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Physician

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Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hyglene. Important: if from 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

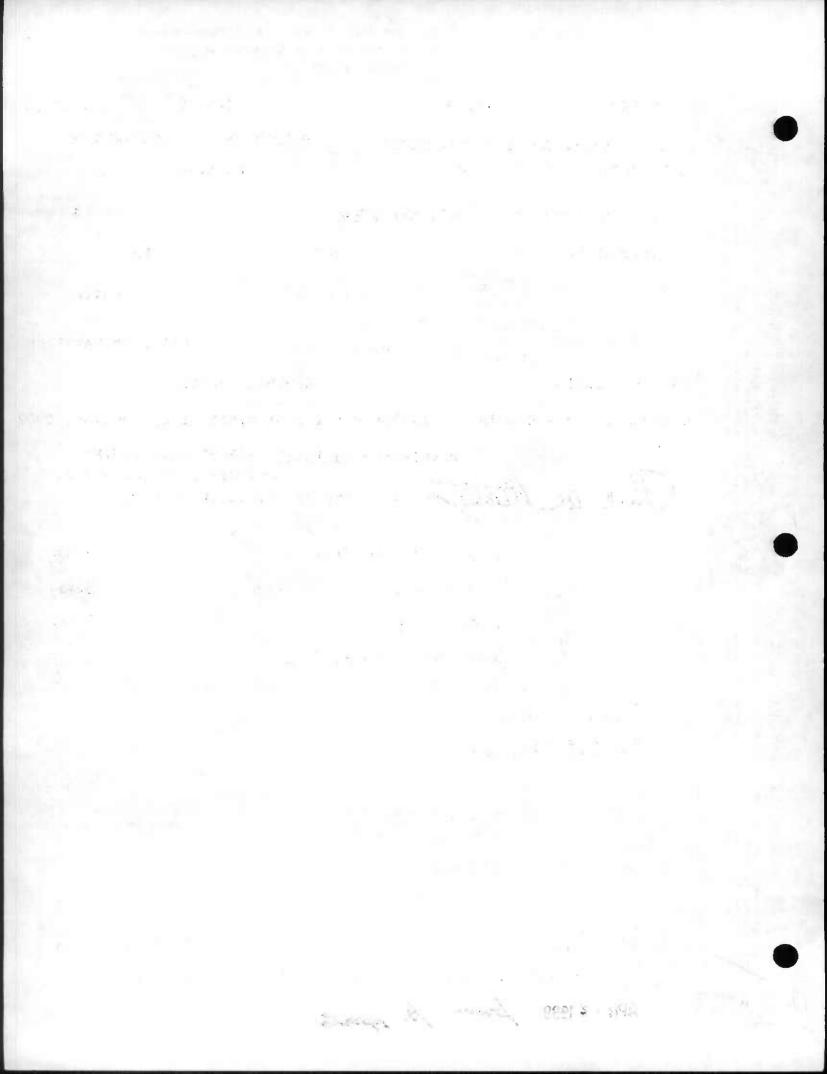
Physician /Medical

Examiner

been signed by the attending physician end should be detached for use es the burial-transit

Baltimore, Maryland 21215-0020

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)
TATINDER. S. SEKHON, 2401 Research Blood #102, Rockvelle, MD 20850 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First Middle Last) 2. Data of Death AGATHA ESTELLA KEAN Month 3 Agatha ean 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Future Care - Old Court Randallstown | H Under 1 Year | H Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | 12/29/1906 Baltimore 5. Social Sacurity Number 6 Sax 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foreign Country) 1□M 2MF Months 218-22-8663 92 Yrs. Maryland Usual Rasidance of Decedant 10a. Stata 10b County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Md. Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 2638 Hess Road 21047 U.S.A. 12. Was Dacadant Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Dacadant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Navar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: 3 Widowed 4 □ Divorced Black 15. Dacedant's Education (Spacify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Domestic Worker Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Charles Hall Ellen Amanda 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Amanda H. Bosley/Daughter 3715 Lamoine Rd. Randallstown, Md. 21133 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) West Liberty Cemetery 1999 Upper Cross Roads. 21. Signatura of Funaral Servica Ligensaa 22. Nama and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. / her 23a. Part1. Enter the disease, or complications that courshock, or heart failure. List only one cause on a course on a course on a course on a course or a course or a course or a course or a course or a course or a course Jarrettsville, Maryland of the death. Do not antar the mode of dying, such as cardiac or respiratory arrast Approximata Intarval Batween Onsat and Daath Immadiata Causa (Final disaasa or condition rasulting in deeth) actial posterition. days Bowel Dua to (or as a consequence of) day deliquation Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Ceuse (Disaasa or Injury that Initieted avants rasulting in daath) Last Dua to (or as e consaquance of) Dua o (or as a consequenca of) Gastrointestinal Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Noknown culation 24b. Wara autopsy findings availabla prior to complation of causa of death? 24a. Was an autopsy parformed? 1 Yas 1 Yas 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be intent of Health and Mental Int: If item 27 is marked of

permit. Page Department of Important: If any Injury or

other traumatic event, the Madical Examiner

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Director

Funeral

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21215-0020

Baltimore, Maryland

attending physician I for use as the buria

Physician/Medical Aq Completed Be 2 Certification:

I or Attanding Physician: The law requires that the death certificate be assecuted after death.

Director: After this certificate has been signed by the attending physician and P.O. Box 68760, ed by the a been signed by should be detac Division of Vital Records, filled in by the within 24 hours a
To the Funeral C Hospital the

> State Registrar

25. Was case rafarred to medical axaminar? 26. Plece of Deeth (Chack only one) 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mennar of Deeth 28b. Tima of 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred Netural 2 Accident 5 Pending invastigetion 1 ☐ Yas 2 ☐ No 3 Suicida 6 Could not ba 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homleide Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medicat Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifian 29b. Signatura and titla of cartifiar 29c. Licansa number 29d. Data signad (Month, Day, Year)

hh wid

D32158

30. Nama and address of person who completed causa of death (Itam 23a) (Type, Print)

Parkh, M.D. 821 N. Ewawst, Suite 407 Vyoten Bultimore, My 2/201-31. Data filed (Month, Day, Year) MAR 1 0 1999 32. Ragistrar's Signature

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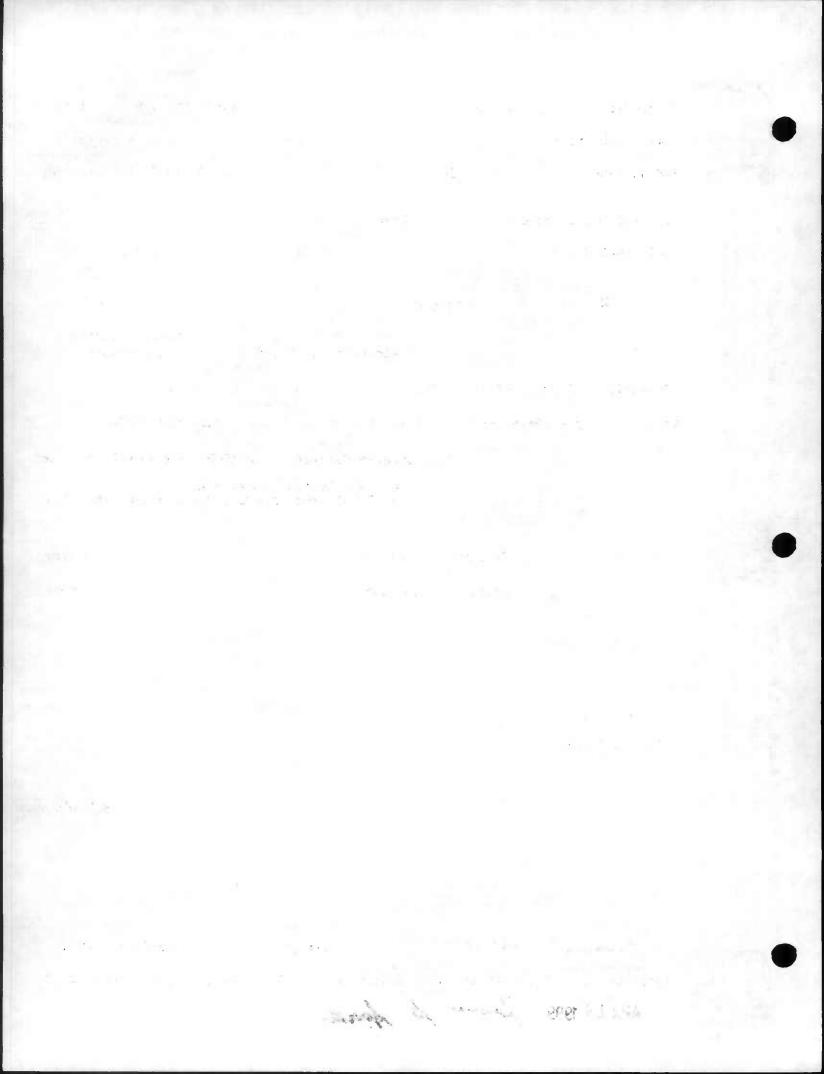
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				Ce	rtificat	e of L	Death	1		g. No.		6	3
cian	1. Decedent's Neme (First, Mid Frederick		Zlaibox	Toe				Moi		Dey	Year		of Deeth Opm
ical iner	4e Fecility Neme (If not institut	-	Klaiber,	Jr.		4	tb. Cify, Town, or		ril]	4c. County		1:3	о рш
ilei	14111 Dub Dr:						Laure	L		Princ		orge'	s
al	5. Social Security Number	6. Sex	7. Age (In yrs		If Under	r 1 Year Devs	If Under 24 Hrs Hours Min	8. Dete	of Birth	Year)	9. Birthpl Count	lece (Stete	or Foreign
	218-38-7369	ILS M Z	58	Yrs.					. 3,	1940			n, DC
	Usuel Residence of Decedent 10a. Stete 10b. Cour	ity	10c. C	ity, Town or L	ocation				_	-	10	Od. Inside	City Limits
to	Maryland Anne	Arunde		La	ure1							1 🗹 Ye	s 2 No
Completed by Funeral Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen of V	Vhet Coun	try?	
2	184 Ethel Dr	ive				20	724			U.S	.A.		
	11. Maritel Status	Arme	Decedent Ever in led Forces? res 2 ☐ No	J,S. 13.	Wes Dece If Yes, spe	dent of Hi city Cube	ispanic Origin? (en, Mexican, Pue	Specify Ye no Rican, e	s or No- etc.)		a - America k, White, e		
2	1 Never Merried 2 M 3 Widowed 4 M Divorc	If Ye	s, Give or Detes: VIET	MAM	1□ Yes	210 No	Specify:			Specify	Whi	te	
20	15. Decad	ent's Education			dent's Usu	el Occup	etion	ndelm o	1	16b. Kind of Bu	usiness/Ind	lustry	
upie	Elementary/Secondary (0-12	nest grade comple) Colle	ge (1-4or 5+)	life.	DO NOT u	se retired	etion du <i>ring most of wo</i> d)	якиід		Naval	Resea	arch	
5	12			Eng	ineer	ing	Technic				rator	У	
n e	17. Fether's Neme (First, Middl						18. Mother's Na				10)		
0	Frederick 1 19a. Informent's Name/Reletio		Klaiber,	-	ina Addana	- /Ctrant	Alice	Rose		nite	Ctate 7in	Codel	
	Sue H. Bailey						ve, Lau				0708	0000)	
	20e. Method of Disposition	- IOA/I		Pleca of Disp	osition (Ne	me of		Dete	-	20c. Location -		wn, Stete	
	1 Buriel 2 ☐ Crematio 4 ☐ Donetion 5 ☐ Other			cemetery, cre				04/15/	99	Brentwo	- boo	Marv	land
	21. Signeture of Funeral Service		10	2	2. Name er	nd Addres	ss of Fecility			DICHEW	, ou	Tialy.	Land
	1.12	1					neral Ho more Ave			tevill	o MT	20	781
	23a. Pert1. Enter the disease, shock, or heert failure. L	or complications (lst only one ceuse	hat caused the dee on each line.									Approxim Interval B Onset en	ate
	Immediete Ceuse (Final disease or condition		Respirato	ory Fai	lure							24 hc	urs
-	resulting in deeth)	<u> </u>	Due to ((or es e conse	quenca of):	:					1		
nine		b	Cancer of	the L	ung						1	3 mc	nths
EXa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that is listed expers.		Due to (or es e conse	quenca of):						İ		
dicai Examiner	(116f IIIIfigf60 AAGIIf2	C	Due to (or es e conse	Tuence of).								
Medi	resulting in death) Last		500.07	01 00 0 001100	4401100 01).						1		
anyn		d											
Physician/Me	Pert II. Other significant condi	tlone contributing	to death but not re	sulting In the u	underlying o	cause giv	en in Pert I.	23	b. Did to	bacco use co	ntributa to	the caus	e of death?
	Hypoanemia								1 🗆 Ye	e 2□ No	3⊠ Prot	pably 4	Unknown
a Dy								24	a Was ar	n eutopsy	24b. We	ere autops	v findings
ere	Hypercalcem	ia							perform	ned?	eve	npletion o	r to
Completed									40.4	s 2 🗓 No		deeth?	
2	25. Wes case referred to media	ral					26. Place of De	ath (Chan	1 🗆 Ye		1	Yes 2	□ No
0 8	exeminer? 1 ☐ Yes 2 ☒ No	Hospital:	1 ☐ Inpatient 2 ☐	☐ ER/Outpatie	nt 3 D	OA Oth					er /Special	iend'	s House
h: T	27. Manner of Death		Date of Injury (Month, Dey Year)	28b. Time o		28c. Injun Worl		_	_	w injury occur		,	
atio	1 Netural 5 ☐ Pend 2 ☐ Accident inve	ding stigation	WORLII, Dey Tear)	Injury	М		Yes 2 □ No						
Certification:	3 Sulcide 6 Coul 4 Homicide dete	mined 200. I	Place of Injury - At touilding, etc. (Spec	nome, farm, st	reet, factor	y, offica			ation (Str or Town	reet and Numb , Stete)	er or Rura	I Route N	umber,
edicai (al Examinar: On t	the best of my kn he basis of examin manner stated.										e(s)
M	29b. Signeture end title of certi				29	c. Licens	e number		29	9d. Date signe	d (Month, I	Dey, Year)
- 1	marde	, D. W	eltzm	^ .		D2	23743			April	14,	1999	
11	30. Name and eddress of person Martin Weltz,	on who completed	cause of deeth (Ite	m 23e) (Type									

DHMH 16 Rav 6/95



0 State

31. Dete filed (Month, Dev. Year)

29b. Signature end title of certifier

APR 1 4 1999

haram O. Welt

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1525 STIGU I WITSHIM 32. Registrar's Signature

29c. License number

D23743

29d. Date signed (Month, Dey, Year)

Registrar

BANK TO THE STATE OF THE STATE

Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month 3 Day CEMENINE KNUGHT 26 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince Georges 9. Birthplaca (State or Foreign Country) 1950 North Carolina 12502 Guinivere Rd. GlennDale or If Under 24 Hrs. s Hours Min. 5. Social Security Number If Under 1 Year 7. Aga (In yrs. last birthday) 1 M XX Months Days 48 Yrs. 579-66-5739 Usual Rasidanca of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limits Yas 2 No Prince Georges **GlennDale** 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 12502 Guinivere Rd United States o- 14. Race - American Indian, Black, Whita, atc. 20769 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Specify: Black 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) Para Legal Judicial 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert L. Knight Lucille Moocher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Ralationship (Type, Print) Gwendolyn Knight Sister 801 Reedworth Ct. Capital Hgts. 20743 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Other (Specify) Lincoln Cem/ 4/1/99 Brentwood, Md. 21. Signature of Funaral Şarviçe Licana 22. Nama and Address of Facility Ft. Lincoln F.H. B401 Bladensburg Rd. Brentwood, Md. 20722 ous Pdf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one ceuse on each line. Approximata Intervel Betweer Onset and Death Immediata Causa (Final disease or condition resulting in death) MATASTATIC BrEAST CONCER Due to (or as a consequence of): Sequentially list conditions, if any, laading to immadieta causa. Entar Underlying Causa (Disease or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was casa ratarred to medical axaminar? 26. Place of Death (Check only one)

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

permit. Paga Department of Important: If any Injury or once.

Physician

/Medical

Examiner

Funeral

Director

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Funeral Director

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filed within 72 hours after

Pagas 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Merical or other traumatic event, the Merical or other traumatic event, the Merical or other traumatic event, the Merical or other traumatic event, the Merical or other traumatic event, the Merical or other traumatic event, the Merical or other traumatic event, the Merical or other traumatic events.

Baltimore, Maryland 21215-0020

The law requires that the death certificate be executed the for use ate has been signed by the page 2 should be detached this

funeral

Division of Vital Records, or Attending Physician: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun

Box 68760

P.O.

10

Medical Certification: To Be

State Registrar

(111 2

5 Panding invastigation

6 Could not be determined

1 Certifying Physician: To the bast of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end menner es steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifiar 29c. License number

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Injury

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28a. Deta of Injury (Month, Day Year)

18320

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Data signed (Month, Day, Year) 3/31

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

John Fetting MD. Johns Hopicius Opiolos-1 CESTER 600 N. Welfre 84. Brainon M2 21267.

31. Data tiled (Month, Day, Year)

1 Yas 2 No

27. Mennar of Death

2 Accident

3 ☐ Suicide

4 Homicide

(Check only one)

APR 1 2 1999

32 Registrar's Signatura

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			State of Marylan		artment of I			giene Reg. No.	1 1	156
		1. Decedent's Nama (First, Middle, Last)				2. Data of Da Month	ath Day	Year	3. Time of Death
	Physician /Medical	Agnes Catherine	Kensinger				April	9, 19	99	2:20 pm
	Examiner	4a Facility Name (If not institution, give				4b. City, Town, or L	ocation of Death	4c. County	of Death	
		Saint Catherine's		In a to the last to a day of	If Under 1 Year	Emmitsbu		Frede		(0)-1
	Funeral Director	5. Social Security Number 6. Se 213-38-1542 Usuel Residence of Decedent	x	Yrs.	Months Deys		8. Data of Bir (Month, Da Jan. 2	y, Year) 2, 1905	Count	iace (Stete or Foreign try) sylvania
	puel man	10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	Od. Inside City Limits
	Mery to	Maryland Frederick	c Emn	nitsbur	g					1 ☐ Yes 2 X No
	or 284	10e. Street end Number			10f. Zip Code			10g. Citizen of V	Vhet Coun	iry?
	23a 23a c	331 South Seton A	venue		21727			U.S.A.		
020	d 2 should be filed within 72 hours effer death with the Merylend and Mental Hyglene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar mant be notified at To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedant Evar in U, Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Give Year or Dates:		Was Decedent of f Yas, specify Cub 1 ☐ Yes 2 ☒ No	Hispanic Origin? (Spean, Mexicen, Puerto Specify:	pecify Yas or No o Ricen, etc.)	Specify	e - America k, White, d Whi	etc.
Ŏ-	2 ho	15. Decedent's Edu		16a. Deced	dent's Usuai Occu	pation	kina	16b. Kind of Bu	siness/Ind	lustry
Maryland 21215-0020	ed within 72 ho yglene. her than "netura rt, the Wrotcall Completed	(Spacify only highast grad	College (1-4or 5+)			during most of world)	King		-	ge's County
7	Per ti	17. Fathar's Nama (First, Middla, Lest)	5+	Teach	ner	18. Mother's Nan	ne /First Middle	Public		ols
and	nital H ed out	Benedict Monohan				Mary He			107	
7	should Men market matic	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	ng Address (Stree	at end Number or Ru			Stete, Zip	Code)
		James L. Kensinger				Avenue,				
re,	f Health item 27 other tr	20e. Method of Disposition	20b. P	lace of Dispo	sition (Neme of netory or other ple	1	Date	20c. Location -		
Baltimore,	permit. Pages 1 an Depertment of Heal Important: If Item 2 any Injury or other DDCs.	1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from Stata		ivet Cem		4/13/99	Washin	zton.	DC
	Physician /Medical Examiner	23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediata Causa (Final disease or condition resulting in death)	a. Ischemic Car Due to (c Coronary Art	h. Do not ent	4739 Baler tha mode of dy opathy quence of):	ess of Facility Funeral Ho timore Av- ing, such as cardiac	enue, Hy	yattsvil		Approximate Interval Between Onset and Death 5 Years 0 Years
687	requires that the death certificete be executed teen signed by the ettending physicien and hould be deteched for use as the buriet-transit eted by Physiclan/Medical Examin	Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated avants resulting in death) Last	Hypertension						3	30 Years
m ·	death e ette d for	Part II. Other algnificant conditions con	ntributing to death but not res	utting in the u	nderiving cause o	iven in Part I.	23b. Dld	tobacco usa co	ntribute to	the cause of death?
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Division of Vital Records,	been s should leted	Osteoporosis						an autopsy ormed?	ava coi	ere autopsy findings ailable prior to mpletion of ceuse death?
Ě	The law of the law page 2 st	Breast and Endome	trial Cancer				10	Yes 2∑No	10	Yes 2□ No
Ta	slan: ertifice ector, Be C	25. Was cese referred to medicei examiner?				26. Place of Dea	th (Check only	one)		
>	hysic his ce il dire	1 ☐ Yes 2 ☒ No	Hospitai: 1 ☐ Inpatient 2 ☐	ER/Outpatier	IT 3LI DOA		ome 5□Resi	dence 6 Oth	er (Specif	v)
sion	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Compi	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	W	uryat ork? ☐ Yes 2 ☐ No	28d. Describe	how injury occur	red	
DIVI	s after de la Directe ed in by te Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str y)	eet, factory, office		28f. Location (City or To	(Street end Numb wn, Stete)	er or Rura	I Route Number,
	n 24 hour n 24 hour ne Funer pletely fill edical		sician: To the best of my kno ner: On the basis of examina end manner stated.							
	M Pomp	29b. Signature and title of certifier			29c. Lican	ise number		29d. Date signe	d (Month,	Dey, Year)
)	(15)	30. Name and addrass of person who co	ompleted cause of death (Iten	23a) (Type.	Print)	037		4/ 0	191	77
	()	Bonita J. Krempel				on Avenue	, Emmits	sburg, M	ary1a	and 21727
		31. Date filed (Month, Day, Year)	32. Registrar's Signa						-	

Registrar

APR 1 6 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 5RN AP EORGE 10 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (PR 13, 191 MARD JENERAL MUNTY - BSPITA HOWBUDI 7. Age (In yrs. last birthday) If Under 1 Year Birthpleca (State or Foreign Country) 5. Sociel Security Number **Funeral** Months 1 MM 20 F Deys 060-09-600 Director New York Usuel Residence of Decedent the Manyand 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow r than "natural", or items 23s or 28s-f show 1 Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10818 Vista Road 21044 United States Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? Bleck, White, etc. d 2 should be filed within 72 hours after the and Mental Hygiena. 77 is marked other than "natural", or its treumatic event, or leading to the continuation of the con 1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify à 3 ₩ Widowed 4 Divorced Yeer or Dates: White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Purchasing Agent Insurance 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked oth any Injury or other treumatic event anse. Be George L. Kern Harriet Lawton 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Schaefer/Daughter 10818 Vista Road Columbia, Maryland 21044 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Dete ₩ Buriel 2 Cremetion 3 Nemoval from Stete 4 ☐ Donation 5 ☐ Other (Specify) 4-15-99 Long Island Nat'l Cem. Farmingdale, NY 21. Signeture of Funerel Service Licenses 22. Neme end Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the deeth) Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. 4112 Old Columbia Pike Ellicott City, MD 21043 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Fine) naus disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner physicien and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Box 68760. mound Physician/Medical Due to (or as e conse uenca of): 88 esn nse for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? Records. P.O. signed by t 1 Yes 2 No 3 Probably Whitnown þ should I 24a. Wes en eutopsy performed? 24b. Were eutopsy tindings eveilable prior to Completed completion of cause of death? page 2 1 Yes & No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physicien: funeral director. Be 25. Was case reterred to medicat examiner? 28. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2010 NZEN/Outpetient 3□ DOA 1 Inpatient After this 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Returel 5 Pending 1 Yes 2 No death. 2 Accident investigetion 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide filled in Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner as steled. 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner steled. edical 29e. Certifier within 24 hou To the Fune completely fi (Check only

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State

Registrar DHMH 16 Rev 6/95

one)

29b. Signature end

31. Dete filed (Month, Day,

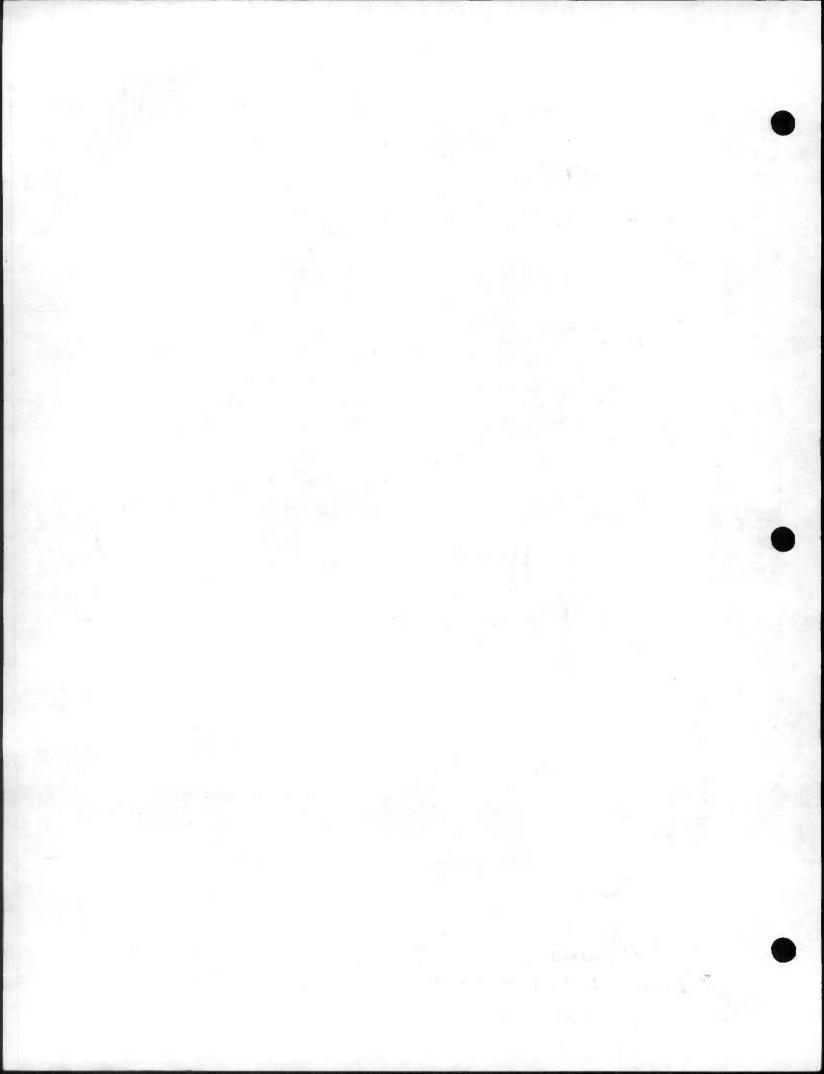
itle ot certifie

WHE Pstutt 055 32, Registrer's Signeture

Nome and address of person who completed cause of death (Itom 23a) (Type, Print)

29c. License numbe

29d. Date signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month 359 APRIL King Masako Manabe 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva straat and number) 4427 RENG ROAD r-3 GEORGES SUITLAND PRINCE #7 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) 63 Yrs. Birthplace (State or Foreign Country) 5. Social Security Number Months Days 1 M ZOXF 018-34-1654 July 16,1935 Japan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Suitland Maryland Prince George's 10e. Street and Number 4427 Rena Road T-3 10f. Zip Code 10g. Citizen of What Country? Japan 20746 14. Race - American Indien, Black, White, etc. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Japanese 1 ☐ Yes 2 No Spacify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Andrews Air Force Base 12th House Cleaner N/A 18. Mother's Name (First, Middla, Maiden Surnama) 17. Fether's Name (First, Middle, Lest) Maki Sudo Tsurumatsu Manabe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informent's Name/Relationship (Type, Print) 4427 Rena Road T-3, Suitland, Maryland 20746 Marvin King (HUSBAND) 20b. Place of Disposition (Nama of cematery, crematory or other place) April 20a. Method of Disposition 15, Date 20c. Location - City or Town, State 1 Durial 200 emation 3 Removal from State Clinton, Maryland Lee Crematory 4 ☐ Donation 5 ☐ Other (Spacify) 1999 22. Name and Address of Fecility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 cce 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) . ARTERIOSCUEPOTIC CARDIOVASCULAR Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es e consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 Unknown PICK'S DISEASE 24a. Was an autopsy performed? 24b. Were autopsy findings eveileble prior to completion of cause of death? 25. Wes case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Chack only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Deeth 28a. Dete of Injury (Month, Day Yaar) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 2 ☐ Accident 2 🗆 No 1 Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Funeral

Director

Itsm 27 is marked other than "natural", or items 23a or 28a-f show other treumstic svent, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or how any injury or other traumatic many.

Baltimore, Maryland 21215-0020

with the Marylend

Examiner physician and s the buriel-trensit Physician/Medical 80 esn signed by I þ Completed director, Be 10 funeral Certification:

requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. or Attending Physician: efter death. Director: After this certific Hospital c
 24 hours a
 Funeral D

10

completely To the To the To the I

> State Registrar

edical

30. Name and address of person who comple MARLO GOLLE

3 Suicide

29a. Certifier

4 Homicide

6 Could not be determined

cause of deeth/(I)om 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3001 HOSPITTAL

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated.

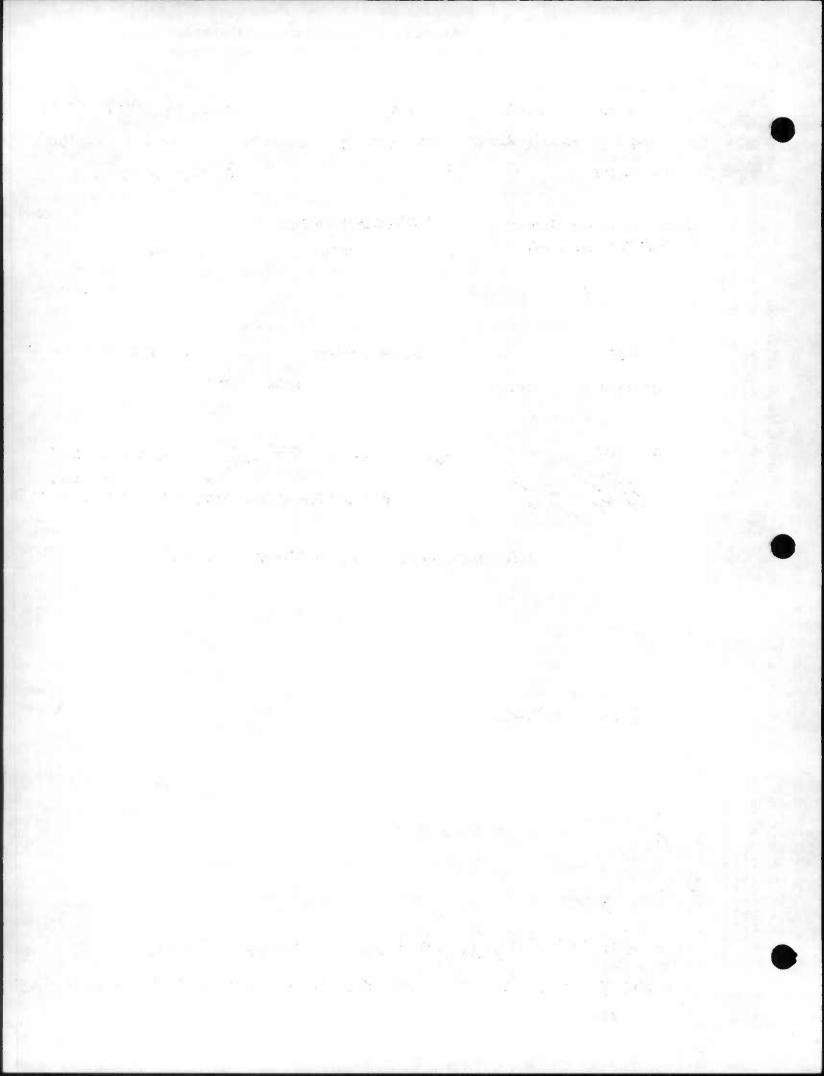
29c. License number

29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DRIVE, CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 0 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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Funeral Director	5. Social Security Number 220–16–4979	0	(In yrs. last birthday) 84 Yrs.	If Under 1 Yaar Months Days	If Undar 24 Hrs.	8. Data of Birth (Month, Dey, July 14			ace (Stata or Foraign
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\$ 0 B C	10e. Street and Number 420 W. Dares	Beach Road #4	14	10f. Zip Code 20	678	1	0g. Citizan of W USA		ry?
020 urs efter aff., or he	3 Widowed 4 □ Divorced	12. Was Decedent E- Armed Forcas? ed 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas:	ver in U,S. 13.	Was Decedent of If Yas, specify Cut 1 ☐ Yas 24 No	Hispanic Origin? (Spoan, Mexican, Puarto Specify:	pecify Yas or No- Rican, atc.)	Black	- Amarica c, Whita, a Black	itc.
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Dege anto	20a. Mathod of Disposition 1		20b. Place of Dispo cematary, cree Mt. Oliv	matory or other pla		Date /19/99 P	20c. Location - C		
Baltimo	21. Signature of Funaral Sarvice L	Sewell		2. Nama and Addr	ass of Facility Se Beach Rd	well Fun			MD 20678
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ords, P.O. Box requires that the death cert each signed by the ettendin hould be detected for use	chronic	renal 11	nsuffic	u'enc	y,	1 🗆 Y	1_/		ebly 4 Unknown
requirements	gout, de	mentio				24a. Was e perform	n autopsy ned?	ava	re eutopsy findings illabla prior to npletion of causa leath?
f Vital Rec ystolen: The law is certificate hes director, page 2						1 🗆 Ya	as 200 No	1 🗆	Yas 2□ No
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To the Hospital Within 24 hours To the Funeral completely filled Medical Co	29a. Cartifiar Certifying (Check only 2 Medical E	Physician: To the best of examiner: On the basis of a and manner state	xaminetion and/or in	n occurred at the t vastigation, in my	ime, dete end place, opinion, daath occur	and due to the corred at the tima, d	ause(s) and mer ete and place, e	nner as ste and dua to	ated. tha cause(s)
To th To th comp	29b. Signature and titla of certifier		4	29c. Lican	sa number	2	9d. Data signed	(Month, L	Day, Year)
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State Registrar	31. Data filed (Month, Day, Year)	32. Registrar	s Signatura	6. 1	100 Val				

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			-	Department of Certificate o			. No.	19100
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niner	4a. Fecility Name (If not institution, give Charlotte Hall \		ma		4b. City, Town, or L Charlotte			ty of Deeth Mary s
ai	Social Security Number 6. S	ex 7. Age	(In yrs. last birt		ar If Undar 24 Hrs.	8. Date of Birth		9. Birthplace (State or For
or .	074-18-1410 Usuel Residence of Decedent	ZM 2□F 76		Yrs. Months Dey	s Hours Min.	Sept. 5	1922	New York
	10a. State 10b. County		IOc. City, Town		-			10d. Inside City Lin
ctor	Maryland St. Mary			arlotte Hal				1 ☐ Yes 2 🗹
Funeral Director	10e. Street end Number Charlo 29449 Charlotte Ha		eceran		622	10	U.S.	What Country? A.
ner	11. Marital Status	12. Was Decedant Ev Armed Forcas?	ar in U,S.	13. Was Decedent of	f Hispenic Orlgin? (Sp Jban, Mexican, Puerto	ecify Yes or No-		ace - American Indien, eck, White, atc.
by Fu	1 Never Married 2 Married	1 ☐∯es 2 ☐ No If Yes, Give		1□ Yes Ž Q Ñ		1100111 01017	1	White
	3€ Widowed 4 Divorced 15. Decedent's Ed	Year or Dates:	1946	Decedent's Usual Occ	upation	10		Business/Industry
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	12 17. Father's Name (First, Middle, Lest)	2		ech. Engin				l Service - Ar
To Be	Adam Kobe					e (First, Middle, Ma ise K:	Lrwan	ime)
F	19a. Informent's Neme/Relationship (7	Гуре, Print)	19b.	Meiling Address (Stre	et end Number or Rui	rel Route Number,	City or Town	n, Stete, Zip Code)
	Christopher Kobe: 20a. Method of Disposition	rg (SOII)		Disposition (Neme of				- City or Town, Stata
	1 Burial 2 Cremetion 3 4 Donetion 5 Othar (Specify		cemeter	y, cremetory or other p rematory		999		con, Maryland
ė	21. Signature of Funeral Sarvice Lican		1000	-	ress of Facility Le			
SUCE	1 x 6 5 #			6633 Old	Alexandri	a Ferry 1	Road (Clinton, MD 20
	23a. Pert1. Enter tha disaase, or composhock, or heert failure. List only	Mcations thet ceused thone ceuse on each line.	e death. Do n	not enter the mode of d	ying, such as cardiac	or respiretory erres	t,	Approximate Intervel Batween
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Physician/Medical	resulting In death) Lest				DISE	ASE		YEARS
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ysic	Part II. Other eignificant conditions co	ontributing to death but	not rasulting in	the underlying ceusa	givan In Part I.	23b. Did tob	acco usa c	ontribute to the cause of dec
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Completed	HWEKO2CCE	KO IIC	473	Calific	DIZ ENS	E	, ,	completion of causa of deeth? N/A
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Be	25. Was cese referred to medical examiner?	Hospital:				h (Check only one,		
n: To	27. Menner of Deeth	28a. Dete of Injury		ime of 28c. In	4 Nursing Ho	ome 5 Residen	-	
atio	Natural 5 Pending investigation		ear) Ir		Yes 2 No			
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homlcide determined	28e. Plece of Injury building, etc. (- At home, fai (Specify)	rm, street, factory, offic	е	28f. Location (Stre City or Town,		nber or Rurel Route Number,
	29a. Certifier Certifying Phy	yeician: To the best of r	ny knowledge	death occurred at the	time dete and place	and due to the co-	ea(e) and -	nannar as stated
edicai	(Check only 2 Medical Exam	iner: On the basis of exercises and menner state	camination end	Vor Investigetion, in my	opinion, deeth occur	red et the time, det	e end place	nenner es steted. n, end due to the ceuse(s)
1 =	29b. Signature and title of certifiar	0	-	29c. Lice	nsa number	290	I. Data sign	ed (Month, Dey, Year)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 1999 03% Ida Elizabeth Luber 6:45 pm 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street and number) Hillhaven Nursing Center, Inc. Adelphi Prince George If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 1□M 2₽F Months Days Hours Min. 89 Yrs June 4, 1909 | Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Prince George Laurel 10f. Zip Code 10g. Citizen of Whet Country? 20707 USA 414 Compton Avenue 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Elementery/Secondary (0-12) College (1-4or 5+) Secretary Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Regina Gordon ALfred Henry Anderson 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1143 12th Street, Laurel, Maryland 20707 Sara Jean Binder /daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4/6/99 Ivy Hill Cemetery Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fusions. List only one cause on each line. Approximate interval Between Onset end Deeth Cerebrovascular Accident Days Due to (or as a consequence of): Due to (or as a consequence of): Due to (or es e consequence of):

Physician /Medical **Examiner**

the deeth cartificata be executed

Box 68760,

P.O.

Division of Vital Records,

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Hospital or Attending Physician:

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within 24 hours a To the Funeral C complately filled

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Physician

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 2 and injury or other traumatic event, the Medical Example must be nonce.

altimore, Maryland 21215-0020

5. Social Security Number

212-10-7968

10e. Street and Number

11. Meritel Status

Grade 12

20a. Method of Disposition

10a. State

MD

Director

Funeral

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Completed

inding physician and usa es the buriel-trans signed by the a page 2 should b cartificata has funeral director,

Examiner Physician/Medical þ Completed Be P Certification:

Immediete Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings evallable prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one)

157 Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D24997

29d. Date signed (Month, Dey, Year)

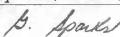
April 5, 1999

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

8317 Cherry Lane, Laurel, Maryland 20707 Luis A. Casas, M.D.

31. Date filed (Month, Day, Year) APR 06

32. Registrar's Signeture



State Registrar

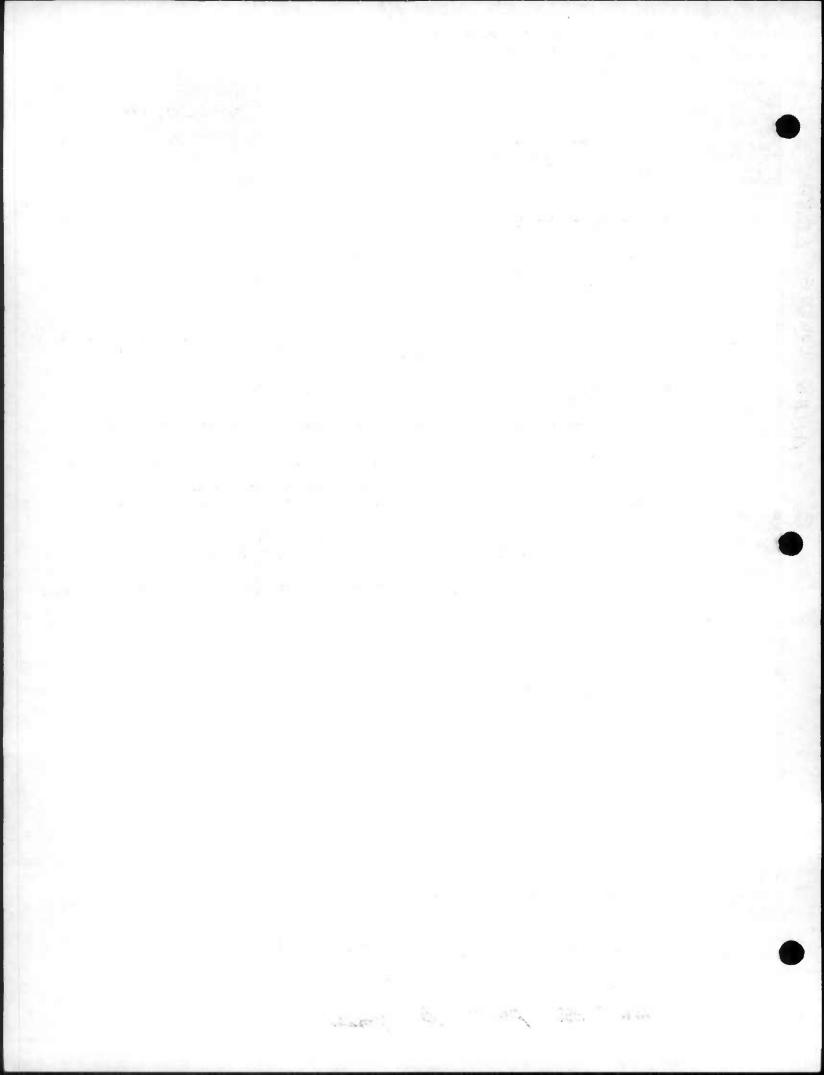
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State of Maryland / Department of Health and Mental Hygiene

			Decedant's Nama (First, Midd	lla (ast)		Cer	tificate of	Death	2. Data of De	Reg. No.		3. Tima of Death
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	/Medi Examii		4a. Fecility Name (If not institution St. Thomas De			e		4b. City, Town, or Lo Hyattsvil	ocation of Daet	-		
ľ	Funeral Director		5. Social Security Number 242–26–5849	6. Sax 1 ☑ M 2 □ F	7. Aga (In yrs. le 75	ast birthday) Yrs.	If Undar 1 Year Months Days		8. Date of Bir (Month, De 12-16-	th ay, Year) -23	9. Birthple Count Nort	aca (State or Foreign (y) h Carolina
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Z	should be fand Mentel Fand Mentel Fand Mentel Fand of Mentel Fand	To	19e. Informant's Name/Ralations	shin (Tyne Print)		19h Mailin	n Addrass (Straa	at and Number or Rur			Steta Zin	Code)
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Baltimore,			20a. Method of Disposition 12 Buriel 2 □ Crametion 4 □ Donation 5 □ Other (5		State	matary, crem	sition (Nama of eatory or other pla coln Cer		Data9-99	20c. Location - Brentw		_{vm, Stata} Maryland
Balt	permit. Page Department of Important: If any Injury or		21. Signature of Funeral Service	Short	af			rass of Facility Str ntown Road				vices, P.A 20748
	Physician /Medical	1	Part Enter the diseasa, or heart feilura. List Immediata Causa (Final diseasa or condition									Approximata Intarval Batween Onsat and Death
	Examiner	iner	resulting in deeth)	a	Egp to (or	as a consequ	uanca of):	hythm	1500.	50	-	Mos
60,	The law requires that the death certificate be executed at has been signed by the ettending physician end page 2 should be deteched for use as the buriel-trensit	ai Examiner	Sequentially list conditions, if any, leading to immadiata causa. Entar Undartying Causa (Disaasa or Injury	S	Dua to (or	as a consequent	Sance of): Fensi	(1	10415
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Vital Records,	s been sig 2 should b	Completed b							24a. Was	an autopsy ormad?	eva	re autopsy findings illabla prior to nplation of causa leath?
- R	The law ate has page 2:	Com							10	Yas No	1 🗆	Yas 20 No
Vita	Physician: The this certificate rel director, pag	Be	25. Was casa rafarrad to medica examinar?	Hospitel:				26. Plece of Deet	h (Check only	one)		
of	ng Phys fter this inerel di	tion: To	1 Yas 2 No 27. Mannar of Death 1 Natural 5 Pandii 2 Accidant investi	28e. Data o		ER/Outpatient 28b. Tima of Injury	28c. Inju			dence 6 □Oth how injury occur)
Division	To the Hospital or Attanding within 24 hours effer death. To the Funeral Director: Affer completely filled in by the fune	Certification:	3 Suicide 6 Could 4 Homicida determ	not be 28a. Place	of Injury - At horing, etc. (Specify,		et, factory, office		28f. Location (City or To	Straat and Numb wn, Stata)	ber or Rural	Routa Number,
	Hospitu 24 hours Funeral	edicai (29a. Cartifiar 12 Cartifyin (Check only one)	ng Physician: To tha i Examiner: On tha ba and mann	sls of axaminati	riedge, death on end/or inv	occurred at the t astigation, in my	lma, deta and place, opinion, daath occur	and dua to tha red at tha tima,	causa(s) and madata and placa,	annar as sta and dua to	ated. the causa(s)
	To the To the comp	Me	29b. Signature and title of certific		3/	1	29c. Licen	22 708		29d. Date signa	8 - 9	Mr
5	(6)		30. Nama and addrass of person Dr. Meer	who completed cause said Zonoz				nue, SE Wa			- /	
	Sta Registr		31. Data filed (Month, Day, Year,		egistrar's Signati	ured.	boards	/				

State of Maryland / Department of Health and Mental Hygiene

					(Certifica		Death		Reg. No.	2 1	4163
	Physic	ian	Decedent's Neme (First, Middle, Last)						2. Dete of De Month	eth Dey	Yeer	3. Time of Deeth
	/Med	ical		ska, Sr.					APRI	49,1	1999	10:03 pm
	Exami	ner	4e. Fecility Neme (If not institution, give: Doctors Comm	unity Hos	aitel			4b. City, Town, or Lanhar			y of Deeth	zorge's
	6.000		5. Social Security Number 6. Sep			If Und	der 1 Year					
3	Funeral Director			IM 2□F 53		rs. Month			8. Dete of Bir (Month, De May 8,	1945	Penn	olece (State or Foreign htty) sylvania
Y	dend #		10a. Stete 10b. County	10c.	City, Town	or Location					1	0d. Inside City Limits
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7	th the	irec	10e. Street end Number		-	10f. Z	Zip Code			10g. Citizen of	Whet Coul	ntry?
	ith wi	2	8402 20th Avenue			20	0783			U.S.A.		
116	re, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours after death with the Maryland Heelth and Mentel Hygiena. tam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinatings to notified at	by Funeral Director	11. Meritel Stetus 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	 12. Wes Decedent Ever In Armed Forcas? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates: 	n U,S.			Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ca - Americ ck, White, by: Wh:	etc.
2	2 hou	B	15. Decedent's Educ	cation	16e. C	Decedent's Us	suel Occup	petion		16b. Kind of B	usiness/în	dustry
LUUWI	212 21s	Completed	(Specify only highest grede Elementery/Secondary (0-12)	College (1-4or 5+)				petion during most of work ad)	ing	Plumbi	ing,	Heating &
7	21 ed wi	00		1	Me	chanica	al Co	ontractor		Air Co		ioning
	D de fi	Be	17. Fether's Name (First, Middle, Last)					18. Mother's Nam	•	, Maiden Sumar	ne)	
4	Mer Mer Marke	မ	Joseph S. Liska					Mary Jab				
41LAN	Mand d 2 st d and th and 7 le n traun		19a. Informent's Name/Relationship (Ty)		-			t end Number or Run				
74	Heel The		Sally Ann Liska -		b. Place of [Disposition (N	lame of	enue, Adel	ph1, Ma	aryland 20c. Location		
X	Baltimore, Mi permit. Pages 1 end 2 Department of Heelth a Important: if Item 27 is any injury or other tre once.		1 ☐ Burial 2 ☐ Cremetion 3 ☐ R	emoval from State	cametery,	cremetory or	r other ple					
	Iltir artme ortan injur		4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Servica License		etrope			natory 0	4/13/99	Alexand	ırıa,	Virginia
-	Dep me		00000	- 10	0	Gascl	h's E	Funeral Ho				
00			23a, Pert1, Enter the disease, or compli	eations that caused the de	eath Do no			imore Ave			lle, l	
	Physician		23a. Pert1. Enter the disease, or compli- shock, or heart feilure. List only on	e cause on each line.		. Contor the fire	odo or dyr	ing, odon oo oaraido	or respiratory e	11030,		Approximete Intervel Between Onset end Deeth
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	and trans	Examiner	Sequentially list conditions,	Due to	o (or es e co	ensequenca of	f):	(//				2,5
	be ax cian	E E	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that Initieted events								1	
	68760, fficate be axe g physician a as the buriel-	edicai	thet initieted events resulting in death) Lest	Due to	(or es e co	nsequenca of	f):					
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	ched the G	Physician/M	Pert II. Other significant conditions con	iributing to death but not i	resulting in t	the underlying	g cause gi	ven in Part I.				the cause of death?
	that se detre	by P							10	Yes 2LINO	3 Pro	bably 4∑ Unknown
	LIVISION OT VITAI RECORDS, P.O. BOX 68/6U, To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettanding physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit.	Completed b							24a. Wes	en eutopsy ormed?	ev	ere eutopsy findings eileble prior to mpletion of cause death?
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	ysicia s cer direc	To B	examiner? 1 ☐ Yes 2 No	ospitel: 1 1 Inpatient 2	ER/Outp	etient 3 🗆 [DOA Ott	her:			ner (Specif	iv)
	ION O		27. Menner of Deeth 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident Investigation	28e. Dete of Injury (Month, Day Yeer)		ne of	28c. Inju Wo 1			how injury occur		
	DIVIS al or Atte s after day if Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homlcide determined	28e. Placa of Injury - Albuilding, etc. (Spe	t home, farn	n, street, fecto	ory, office		28f. Location (City or To	Street end Numi wn, Stete)	ber or Rure	el Route Number,
	ne Hospit n 24 hour ne Funere	edical	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my ker: On the basis of exemiend menner stated.	knowledge, of inetion end/	deeth occurre or investigetio	ed et the ti	me, dete end plece, opinion, death occurr	end due to the red et the time,	cause(s) end m dete end plece,	enner es s and due te	teted. o the cause(s)
	Vithii To th	M	29b. Signeture end title of cartifier					se number		29d. Date signe	ed (Month,	Dey, Year)
	0		A o un	orlyer	,	1	D09	1179		4.10	,99	
	(15)		30. Name end eddress of person who con Ata Moshyedi			ype, Print)	4 5	Paite A. G	rreenbel			770
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State of Maryland / Department of Health and Mental Hygiene

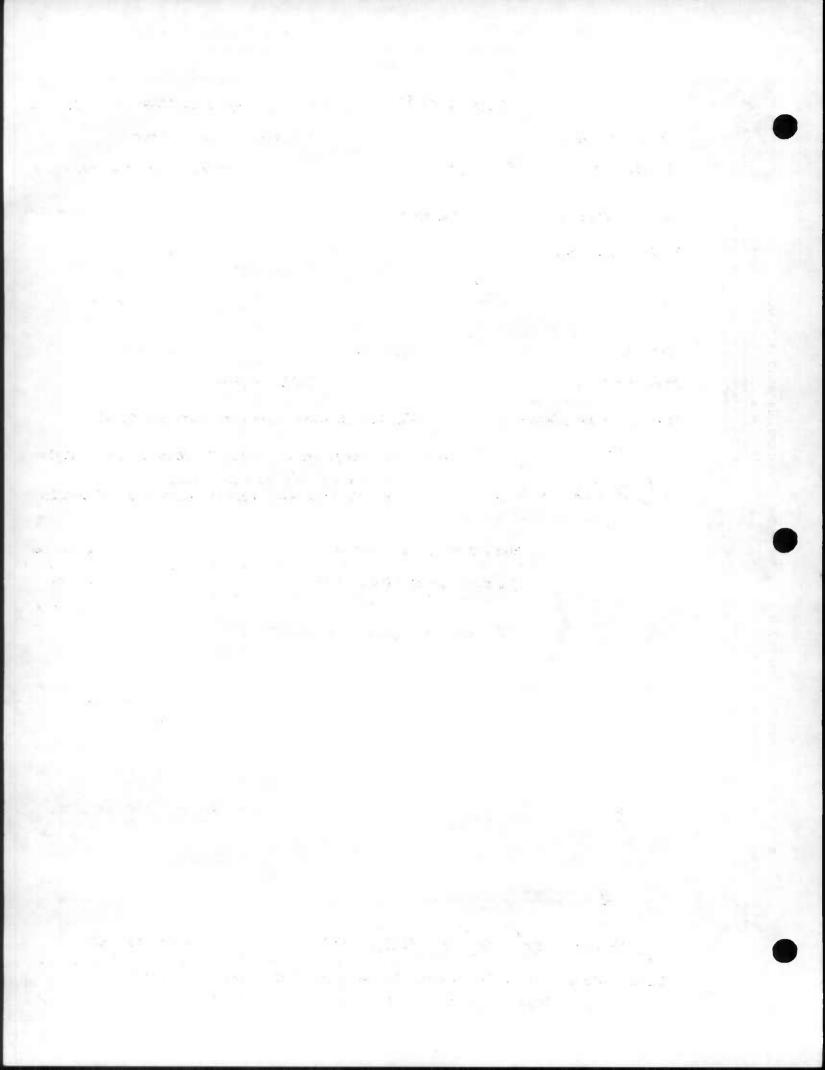
Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Day **Physician** Erma Elizabeth Moore 5:45 am April 03, 1999 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 328 S. Patterson Park Baltimore Baltimore If Undar 1 Year | If Undar 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) **Funeral** 1□ M 21 F Days Hours Min. Yrs. 219-18-9013 75 Director July 7, 1923 Maryland Usuel Residence of Decedant with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No MD Baltimore Baltimore Directo 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 328 S. Patterson Park 21231 USA Funeral death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Raca - American Indian. 11. Marital Status Bleck, White, etc. e filed within 72 hours after al Hygiene. other than "natural", or ite 1 Never Married 2 Married Specify: White 1 ☐ Yas 2 ☐ No Specify: altimore, Maryland 21215-0020 þ 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) United States Elementery/Secondery (0-12) College (1-4or 5+) Government Grade 12 Clerk-typist ith and Mantal Hygie 27 Is marked other r traumatic event, II 17. Fethar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Edward Eugene Goodwin Mae Engel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Thomas O'Neil Rohrback /son 2714 Munson Street, Wheaton, Maryland 20902 20a. Method of Disposition
1 월 Burial 2 □ Crametion 3 □ Removel from State 20b. Plece of Disposition (Nema of camatary, cremetory or other plece) 20c. Location - City or Town, Stata Dete 4/6/99 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailurg. List only one cause on each line. Approximata interval Between Onsat end Deeth **Physician** /Medical Immediate Ceuse (Final hours disaase or condition resulting in death) • Hypertension Examiner Due to (or es e consequença of): Examiner ohysician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Dua to (or es e consequenca of): P.O. Box 68760, physician Physician/Medical Due to (or es e consequence of): 88 attending usa for ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown signed b Records. þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? page 2 should Completed need certificate has 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director Be 25. Wes case referred to medical 26. Plece of Death (Check only one) Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 ☐ Yes 2 No 2 ER/Outpetient 3 DOA After this funeral 28c. Injury et Work? 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of Certification: 1 Neturel 5 Pending after daath. Director: Af investigation 1 Yes 2 No 2 Accident the 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) in by 4 Homicide To the Hospital c within 24 hours a' To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. 29a. Certifier edical 29b. Signeture and otle of certifier 29d. Date signed (Month, Dey, Year) 29c. License number D32294 April 5, 1999 (Item 23e) (Type, Print) 30. Neme end eddress of person who completed cause of deet 100 N. Broadway, Baltimore, Maryland Colin Ottey, M.D. 31. Dete filed (Month, Day, Year) 32/Registrar's Signature State APR 0 6 1999 Registrar 000 Pa

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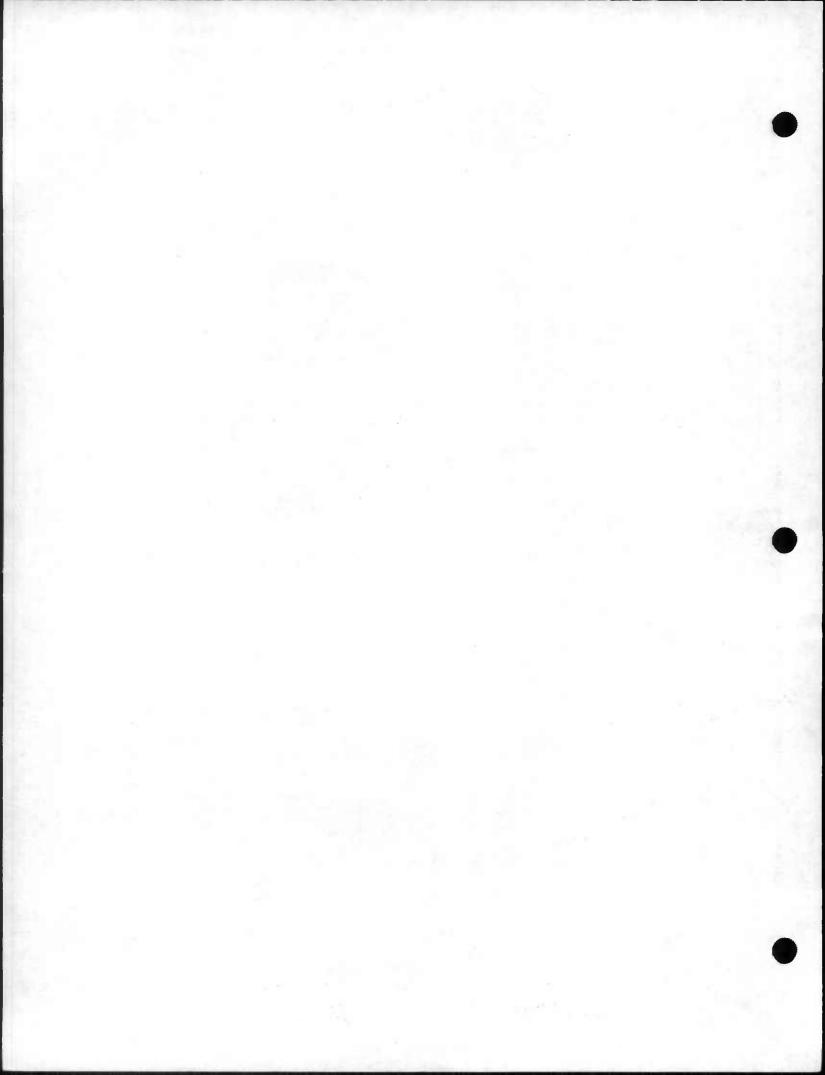
State of Maryland / Department of Health and Mental Hygiene

					•		Cert	ificate	of Deati	h	R	eg. No.		4165	
		1. Decedent's Nam	e (First, Middle, La								2. Dete of Dee Month	th Day	Year	3. Time of De	eath
Physici /Medi				Ma	argare	t Reg	ina	Mir	ızak		April 4		1001	9:05	pm
Examir		4a Facility Name (/	fnot institution, giv						4b. City, 7	Town, or L	ocation of Death	4c. Count	y of Deeth		
		6112 Adc	ock Lane						Hane	over		Howa	rd		
Funeral Director		5. Social Security N 171-12-9		Sex 1□M 2【XF	7. Age (In	n yrs. last bir 7	rrody/	If Under 1 \ Months D	ear If Unde eys Hours	or 24 Hrs. Min.	8. Date of Birth (Month, Day Apr 29	Year) 1921	Cou	place (State or F ntry) nsylvani	
P		Usuel Residence of			140										
Marylar Ff show	tor	MD	10b. County Howard			c. City, Town		ation						10d. Inside City 1 X Yes 2	
r 28g	rec	10e. Street end Nur	mber					10f. Zip Co	de		1	Og. Citizen of	Whet Cou	ntry?	
3a o	O	6112 Adc	ock Lane					2107	6			USA			
deat	Funeral Director	11. Marital Status		12. Wes De Armed F	cedent Eve	r in U,S.	13. Wa	as Deceden	of Hispenic C	Origin? (Sp	pecify Yes or No-		ce - Americack, White,	can Indien,	
72 hours after death with the Maryland naturel; or thems 23e or 28e-f show ottes! Experience must be northed at		1 ☐ Never Marri 3 💆 Widowed	ied 2 Married		2 X No Sive			Tes, specify			nican, etc.)	Speci			
2 hou	8		15. Decedent's E	ducation		16e.	Decede	nt's Usuel O	ccupation			16b. Kind of I			
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semit. Pages 1 and 2 should be filed within 72 hours aft abgardment of Haalih and Mental Hyglene. If it am 27 is marked other than "naturel", or my injury or other traumatic event, the Medical Example.	Co	Grade 12				Но	mema	aker				Own Ho			
al Hoth	Be	17. Fether's Name)							e (First, Middle,	Maiden Suma	me)		
Ment	10	John Mar	tinka						Jul	ia Ma	aticak				
and and me		19a. Informent's Ne	eme/Reletionship	Type, Print)		19b	. Mailing	Address (S	treet and Num	ber or Rui	ral Route Numbe	r, City or Town	, State, Zij	o Code)	
end alth		Regina Fa	alick /da	aughter						Hanc	over, Man	ryland	21076	5	
of He har		20e. Method of Disp		70		20b. Plece of cemeter	Disposit y, crema	tion (Name atory or othe	of r place)		Dete	20c. Location	- City or T	own, State	
Page nent nt: If		4 Donetion	Cremation 3 ☐ 5 ☐ Other (Speci	JHemovel from fy)		Metro	Cre	matory	, Inc.	14	4/10/99	Catons	ville	, Maryla	and
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Department of Health and Mental Hygiena. Instrucelt, or thems 23a or 28a-f show any injury or other traumatic event, the Macinal Endowner man be notified at ance.		21. Signature of Fu	neral Service Lice	place)//	1		22. I	Name end A	ddress of Fed on Fun	eral	Home, P	.A.			
		New	off you	wer.							aurel,		nd 20'		9
		23a. Pert1. Enter to shock, or hee	fallury List only	one ceuse on	eech line.	death. Do i	not enter	tne mode o	aying, such	es cardiec	or respiratory en	rest,	1	Approximate Intervel Betwe Onset and De-	en
Physiclan /Medical		Immediate Cause (End	l stag	e live	er di	isease					1	4 month	
Examiner		resulting in death)		θ		e to (or es e							1		
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ficate be expression as the buria	dical	Cause (Disease or thet initieted events resulting in deeth) I		C	Due	to (or es e o	conseque	ence of):							
attending p	2			d									1		
daath cer e attendir ed for use	ciar														
tha de	Physician/	Part II. Other algnif	icant conditions	contributing to	death but ne	ot resulting in	the und	derlying caus	e given In Pe	rt I.				to the cause of	
det pe											101	as 2LXNo	3 □ Pro	obably 4 Ur	nknow
requires ween sign hould be	Completed by										24e. Was i	an eutopsy	24b. W	Vere autopsy find	dings
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The cate h											1 U Y	es 2 No	1	☐ Yes 2☐ N	0
iclan: The certificate	Be	25. Was case refer examiner?	red to medical	Mosnital						ice of Dea	th (Check only or	ne)			
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i or Attending efter death. Director: Afte d in by the fune	cati	2 Accident	investigation					М	1 ☐ Yes 2	_ No					
ai or Attending is efter death. If Director: After et in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At hom building, etc. (Specify)						et, fectory, o	ffice		28f. Location (S City or Tow	Street and Nun m, State)	nber of Rui	ral Route Numbe	9f,
To the Hospital within 24 hours e To the Funeral Completaly filled	29a. Certifier (Check only (Check only added) 25 Madical Examinar: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manne (Check only added) 25 Madical Examinar: On the besis of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end														
ithin o the ompl	Me											ed (Month	, Day, Year)		
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Sta Registr		31. Dete filed (Mon	APR 0 6	1999 32.	Registrer's	Signeture	6	1							



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** APri An /Medical 4a Facility Nama (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Undar 1 Yaar If Under 24 Hrs. 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** Months Days 1 X M 2 F Yrs. Feb 11, 1938 Director 444-34-3076 61 Oklahoma Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 TANO Director 288-1 Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? harns 23s or 3033 Oakgreen Circle 21043 United States Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forcas? 14. Race - American Indian, Black, Whita, etc. 72 hours after 1 ☐ Nevar Married 2X Married 1⊠Yas 2□No If Yas, Giva Yaar or Datas: 1959–63 b Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be find within . Department of Health and Mental Hygiens. Important: if them 27 is marked other then "any injury or other traumatic evees, the Mental any injury or other traumatic evees, the Mental any injury or other traumatic evees, the Mental College (1-4or 5+) Elementary/Secondary (0-12) Director Bridge Tournaments 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Joseph Albert Moran Margaret Jane Loughney 19a. Informant's Name/Ralationship (Type, Pnnt) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Carole B. Moran/Wife 3033 Oakgreen Circle Ellicott City, MD 21043 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Cemetery 4-16-99 Marriottsville, MD 22. Nama and Addrass of Facility
Harry H. Witzke's Family Funeral Home, Inc. 21. Signatura of Funaral Sarvice Licensee a 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical METASTATIC Lung Cancer 1euro Examiner Dua to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Sequantially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disaasa or injury that Initiated evants resulting in daath) Last Dua to (or as a consequence of): P.O. Box 68760. use as the Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy page 2 s 2 No 1 ☐ Yas 1 Ves 2 No certificate of Vital Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certifica director. 25. Was casa rafarred to medice! 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 20 No edical Certification: To 1 Impatiant 2 ER/Outpatient 3 DOA in by the funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Division 1 Natural 2 Accident 5 Pending invastigation 1 Yas 2 No 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled filled Dertifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and dua to the ceuse(s) and manner as stated.

2 Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the fime, data and place, and due to the ceuse(s) and manner stated. 29a, Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian 29c. License number PATUXENT Phy Columbin Ms 21044 30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print) 111111145 31. Data filed (Month, Day, Year) APR 1 6 32. Registrar's Signatura State 1999 Registrar



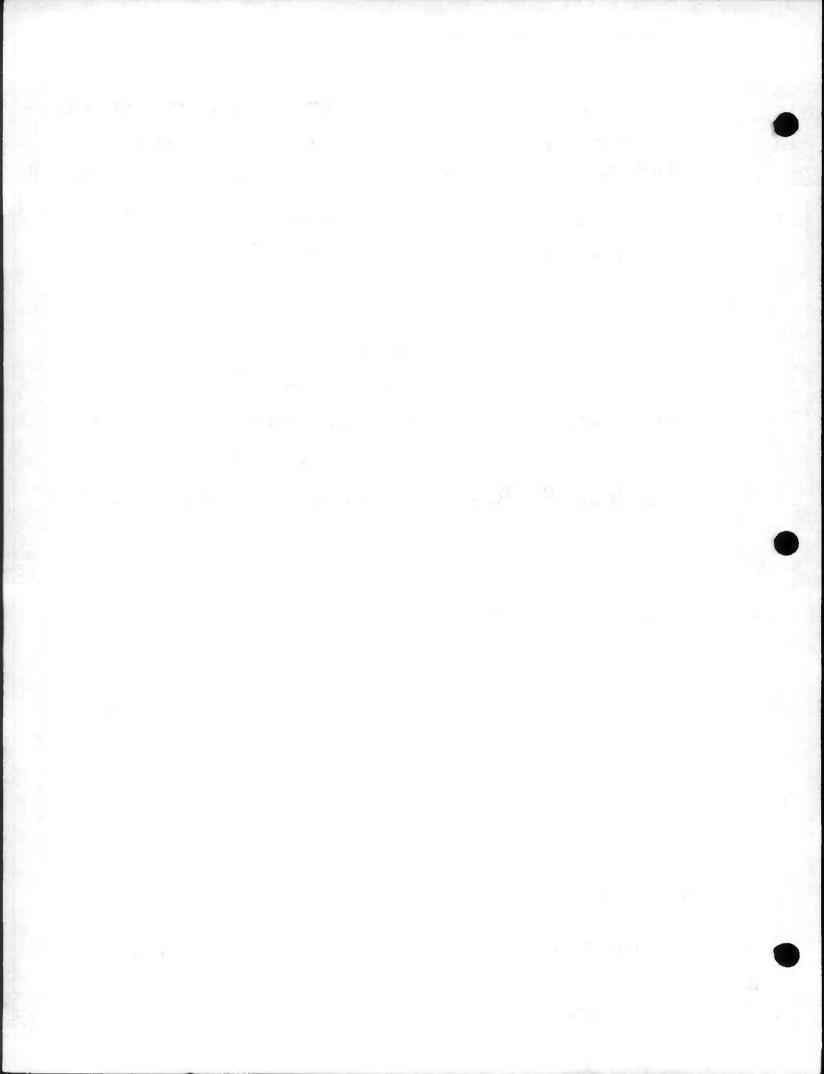
State of Maryland / Department of Health and Mental Hygiene

14167

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ovel.	5. Social Security Number				s. last birthday) If Unde	er 1 Year	If Under 2		8. Date of Bir (Month, De			place (Stete intry)	or Foreign
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To To	Herman Kol	.pack						Grace	e Po	erpoint	-			
mn.	19a. Informant's Name				19b. Mail	ling Addre	ss (Stree	t end Number	or Rure	I Route Numb	er, City or To	wn, Stete, Z	ip Code)	
other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	Raymond Mi	les /so	on		2906	Mile	s Ro	oad, Bu	irto	nsville	e, Mary	land	20866	
or other to	20a. Method of Disposi	ition		20b.	Place of Disp cemetery, cre	osition (N	eme of	ocal .		Date	20c. Locatio	on - City or T	Town, State	
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eteched Physi	Part II. Other elgnificar	ont conditions	contributing to de	ath but not re	sulting in the	underlying	ceuse gi	iven in Part I.			tobacco use		to the caus	
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State of Maryland / Department of Health and Mental Hygiene 9 9

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	dical	JANE	М.		MILI	ER	April		99 1:10 p.m.
	niner	4e. Fecility Neme (If not institution, give s	street end number)				Location of Deeth	4c. County of	
		2203 Chaney Road			1	Dunkirk		Calver	t
Funer Direct		5. Social Security Number 6. Sex 579–07–1980	7. Age (In yr	s. lest birthday, Yrs.	Months Deys			Year) 1919	9. Birthplece (Stete or Foreign Country) Virginia
and *-		10a. Stete 10b. County	10c. 0	City, Town or L	ocation				10d. Inside City Limits
ne Maryli 8a-f sho	ctor	Maryland Calvert			Du	nkirk			1 ☐ Yes 2 No
th with the 23e or 2	Funeral Director	10e. Street end Number 2203 Chaney Road	1		10f. Zip Code 20	754	1	0g. Citizen of Wh	
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, its Madical Examiner must be notified at	þ	1 Never Married 2 Merried	Wes Decedent Ever in Armed Forces? □ Yes 2 ☑ No if Yes, Give Yeer or Detes:		Wes Decedent of If Yes, specify Cub 1 ☐ Yes 2X No		Specify Yes or No- rto Rican, etc.)		- American Indien, White, etc. White
Maryland 21215-0020 td 2 should be filed within 72 hours aft th and Mantal Hyglena. 77 la marked other than *natural; or traumatic event, in Mascal Exam traumatic event, in Mascal Exam	Completed	15. Decedent's Educ (Specify only highest grade Elementery/Secondery (0-12)	cation completed) College (1-4or 5+)		dent's Usuel Occu kind of work done DO NOT use retire			16b. Kind of Busi	
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altimore, mit. Pages 1 ar partmant of Haa portant: If Item;		1 Standard of Disposition 1 Standard 2 □ Cremetion 3 □ Ri 4 □ Donetion 5 □ Other (Specify)	amovel from State	cemetery, cre	metory or other plants. Ga:		4-19-99		onville, MD
Demit. Departimonta	DUCE	21. Signeture of Funerel Service License	. Hon		2. Neme end Addr Rausch Fi		ome, P.A.	, Owing	s, MD 20736
Physicia	n	23a. Pert1. Enter the diseese, or compile shock, or heert feilure. List only on	cations have caused the de e ceuse on each line.	eth. Do not en	ter the mode of dy	ing, such es cardle	ec or respiretory erro	est,	Approximete Intervel Between Onset end Deeth
/Medica	al	Immediete Cause (Finel diseese or condition resulting in deeth)	ling	canel	(3 years
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and Fransit	xamin	Sequentielly list conditions, if any leading to immediate	. Due to	(or es e conse	quence of):				
68 / 60, tificate be executed of physician and as the burial-transit	edical Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	Due to	(or es e consec	quence of):				
BOX 68 auth certifica attending pl	1 100	L d							
d for atte	Ca	Part II. Other significant conditions con	tributing to death but not re	aculting in the I	indadvina cause a	ven in Port I	23h Did to	hacco usa cont	ributa to the cause of death?
that the da	/ Physician/N	1 .	etic phonor.	h		voir iir roit i.	164		3 □ Probably 4 □ Unknown
UNISION OF VITAL MECORDS, P.O. BOX for Attending Physician. The law requires that the death cer affactors: After this cardificate has been signed by the attending in by the funeral director, page 2 should be detached for use	Completed by		•				24e. Wes e		24b. Were autopsy findings eveileble prior to completion of cause of death?
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ID		30. Name and address of person who con Paul V. Pomil			•	Deed 5		2	·
	State	31. Dete filed (Month, Dey, Year)	32. Registrer Sig		nospital	road, Pi	rince Fre	derick,	MD 206/8
Dani	Augus	ADD o 1	1000 N /24	wa	D. 1	20 N.1			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend item #'s 20a-20c Per FH PGC 4-19-99 cr Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 1335 LOUIS APRIL MARRY /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) Examiner LANDOVER 1918 PALMER PARK PRINCE GEORGES Hours Min. 8. Date of Birth (Month, Dey, Y)
March 2, If Under 1 Year Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** N 2□F Months Days 71 Yrs. 1928 Georgia Director 253-28-2821 Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show edical Examiner must be notified at 14 Yes 2 □ No Maryland Prince Georges Palmer Park Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Peges 1 end 2 should be filed within 72 hours efter death with t Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Nems 23a or any Injury or other traumatic event, the Moderal Exams was must be a Dates. 1918 Palmer Park Road 20785 U.S.A. Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 Z No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: ģ Black. 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Private 3rd 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be David Almond Hattie Ruth Lattimore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Martha Mabry/Wife 1918 Palmer Park Rd., Palmer Park, Maryland 20785 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 04/19 20a. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removal from State Forest Hills Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1999 Clinton, Ma Beltsville Maryland Chesapeake Crematory Facility 21. Signature of Funeral Servica Licensee J.B. JENKINS FUNERAL HOME 23a. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

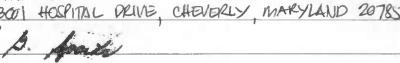
Approximate Approximate Interval Between Onset and Deeth **Physician** fmmediate Cause (Finat disease or condition resulting in deeth) /Medical . ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE **Examiner** Due to (or as e consequence of): Examiner physician end the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequenca of): Box 68760. Physician/Medicai Due to (or es e consequence of) ettending p for use es 80 by the e 23b. Did tobacco use contribute to the cause of death? P.O. Part fl. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert f. signed by t d be detech 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to Completed Deen completion of cause of deeth? page 2 s Ser 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificete Physician: director, 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After thi 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: 1 Naturat ∠ Accident or Attending 5 Pending 1 ☐ Yes 2 ☐ No deeth. Investigation Director: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide the Funeral D the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and menner es steted. edicai (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) o the F 29d. Date signed (Month, Day, Year) 29b. 5 mary 29c. License number

State Registrar 31. Date filed (Month, Day, Year) APR 1 6 1999

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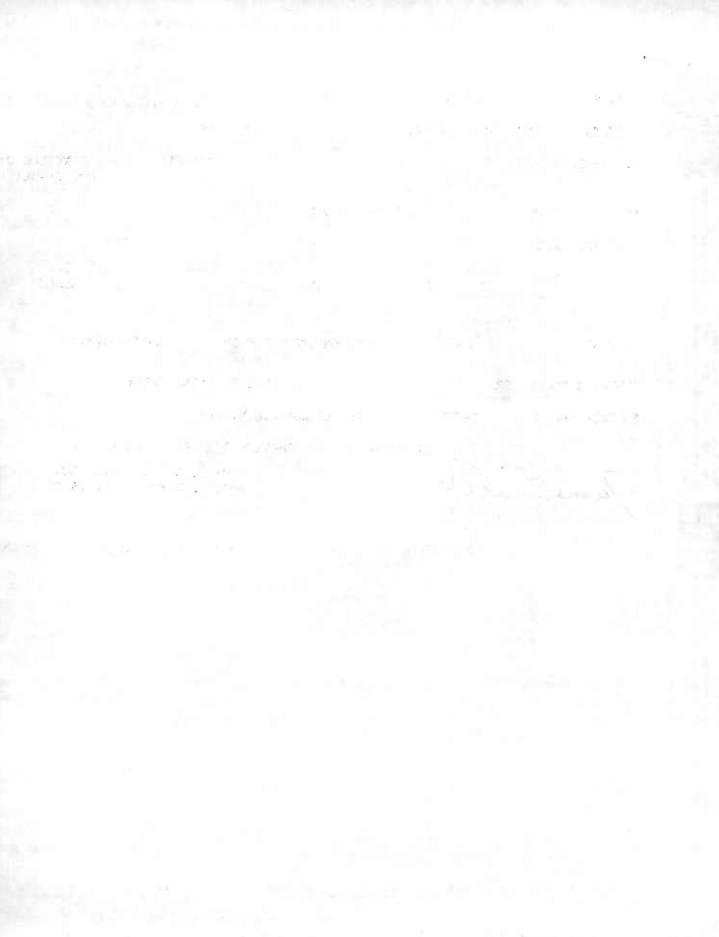


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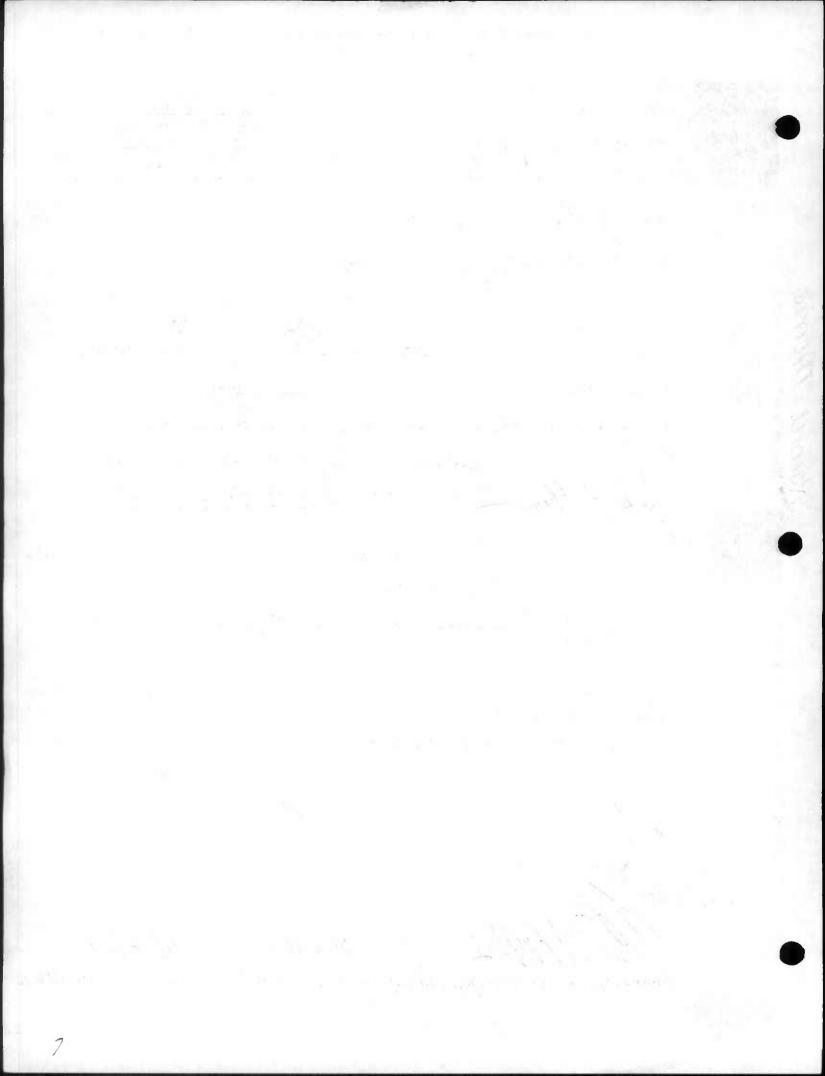
State of Maryland / Department of Health and Mental Hygiene

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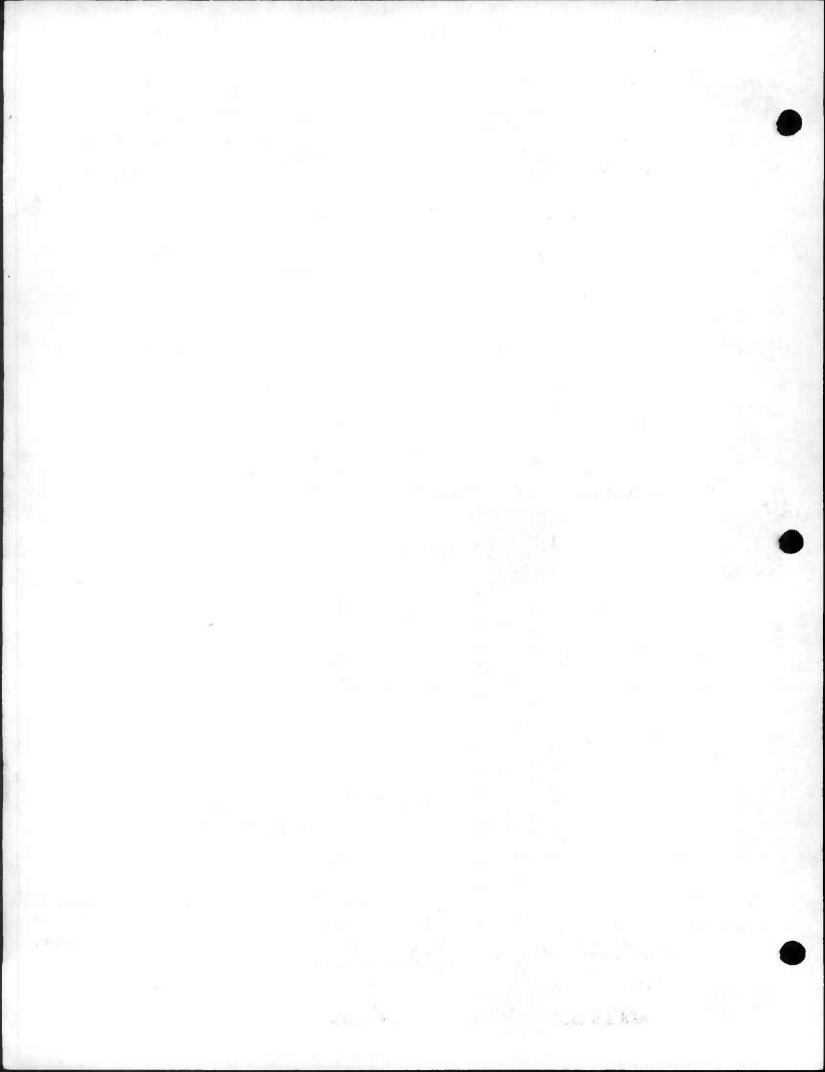
State of Maryland / Department of Health and Mental Hygiene

							tificate of	f Death		Reg. No.		41/	
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Funeral		5. Social Security Num		714 607 5	Aga (In yrs. I	ast birthday)	If Under 1 Yee Months Days		8. Data of Bi (Month, Da April	th v Year)	9. Birthp	lace (Stata or Foraig	n
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N page		Alicia A	. Morri	s (Daugh	ter)	3083	Dorsey	Ccurt Wal	dorf, M	D 20602			
or Heal		20e. Mathod of Dispos			20b. Pl		sition (Nama of natory or other pl		Dete	20c. Location -	City or To	wn, State	
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State of Maryland / Department of Health and Mental Hygiene

					Ce	rtificate c	of Death	7		Reg. No.		9116
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and w		10a. State 10b. County		10c. C	ity. Town or Lo	ocation						Od. Inside City Lim
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th w	<u>a</u>	5717 Jost	St.			20743				U.S	.A.	
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o e e e	E	1 ☐ Never Merried 2 ☐ Marrie	d 1 ☐ Yes	2 No					nicari, etc.)		ack, White,	etc.
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ed of les	Be	William Mort								, maio or ourna	,,,,,	
Me Me	To							annah				
2 sh and is m		19e. Informent's Name/Relationshi	ip (Type, Print)		19b. Mallir	ng Address (Stre	eet and Numb	ber or Rura	I Route Numb	er, City or Town	n, State, Zip	Code)
and and salth		Myra Morton/Wife	<u> </u>		Same	as # 1	0 abov	е				
permitting of the Market Marke		20e. Method of Disposition			Plece of Dispo	sition (Name of matory or other p	olace)		Date	20c. Location	- City or To	own, Stete
Page ent c	-	1 Burial 2 □ Cramation 3 4 □ Donation 5 □ Other (Spe		State	Lincoln	Mem. C	em. 4	/17/9	9	Suitla	nd, M	id.
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sxecuted n and al-transit	Examiner	Sequentially list conditions, if eny, laading to immediata cause. Enter Underlying Ceuse (Disease or Injury	b. C.	Due to (or es e consec or es e consec	m 6	2/6	250	1 d	isea	50	
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or Attending Physicien: Tefter death. Director: After this certificat in by the funeral director, p	To	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 □ In	patient 2	ER/Outpetien	t 3 DOA	Other: 4 N	ursing Hon	ne 5 Resi	denca 6 □Oti	her (Specif	v)
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To the Hospital or Attendi within 24 hours effer death. To the Euneral Director: A completely filled in by the fi												
hours uner	cai	29a. Certifier 1 Certifying	Physician: To the b	pest of my kno	owledge, death	occurred et the	time, date er	nd pleca, e	nd due to the	ceuse(s) end m	enner es s	teted.
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State of Maryland / Department of Health and Mental Hygiene

Second Heart Home Seco				Ce	rtificate	of D	eath		Reg. No.		
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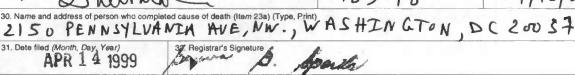
Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** 2:45 Am 04 CLYDE STEWART NEWTON 10 /Medical 4b. City. Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street end number) Examiner Capitol Heights Prince Georges 1505 Arcadia Avenue If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) 6. Sex 1231 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign **Funeral** September 19,1930 North Carolina 68 Yrs. Director 245-46-0628 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Itam 27 ia marked other than "natural", or items 23a or 28a-f shot other traumstic event, the Medical Examiner must be notified at 1X Yes 2 No Directo Maryland Prince Georges Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20743 U.S.A. 1505 Arcadia Avenue death Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?

1 2 Yes 2 \(\subseteq \) No
If Yes, Give 11. Marital Stetus Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, pernit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mentel Hygiene. Important: If item 27 Is marked other than "natural", or iter any injury or other traumatic event, the Wedgell Examinat Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: **Black** à 3 Widowed 4 Divorced Yeer or Dates: 1954 Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10th Laborer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Maggie D. Stewart Floyd Newton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1505 Arcadia Avenue, Capitol Heights, Maryland 20743 Helen M. Newton/Wife 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 04/16 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 1999 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME tercen he 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failured ist only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) **Examiner** Due to (or as e consequence of): Examiner physician end s the buriei-trensit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) P.O. Box 68760, Physician/Medical Due to (or as a consequence of) use as ettending | signed by the el Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably WUnknown Records, g 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peed completion of cause of death? hes 1 ☐ Yes 2 No 1 ∏Yes 2 ☐ No certificate Division of Vital after death.

Director: After this certific director, Be 25. Was cese referred to medice! examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ₹ Residence 6 ☐ Other (Specify) 1 Yes 2 No O. 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral Certification: 27. Menner of Deeth 28a. Date of injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Neture! 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1🗲 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Dete filed (Month, Day, Year) APR 1 4 1999

29b. Signature and title of certifier

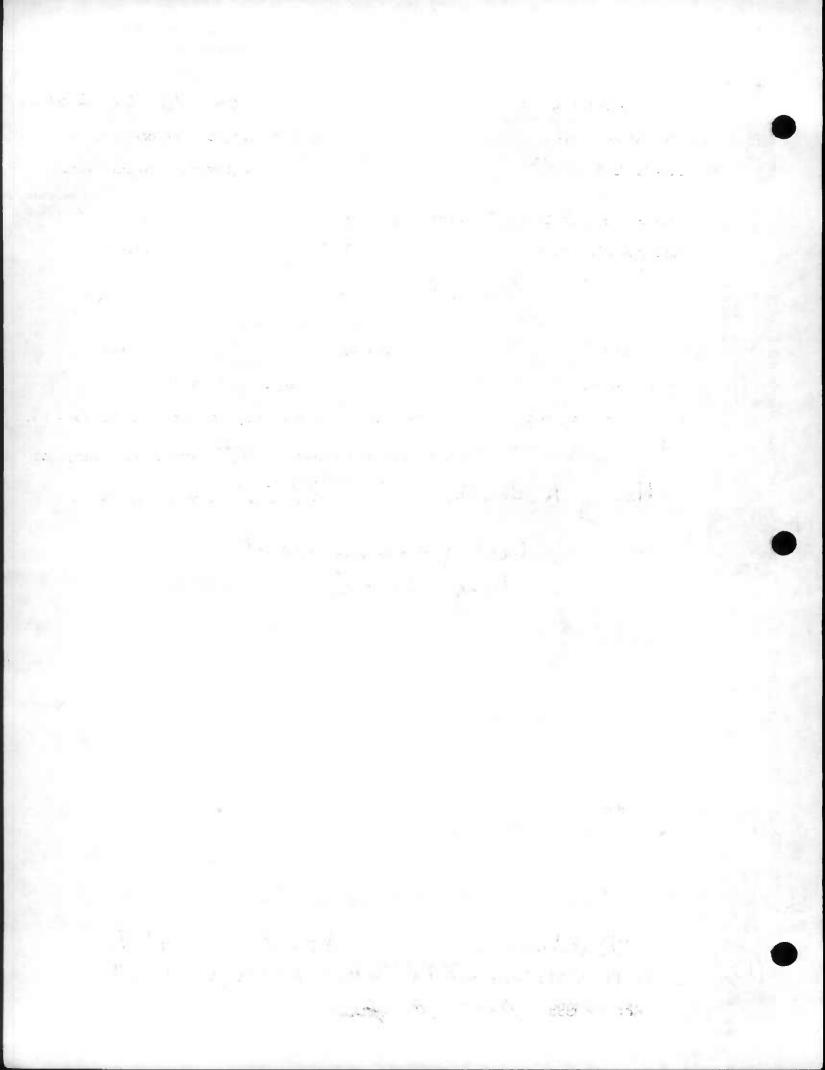


29c. License number

18948

29d. Date signed (Month, Dey, Year)

Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month Dey **Physician** April 16, 1999 2:45 am Carl Hasbrouck Packard /Medical 4e Fecility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner #320 Prince George's 9000 Briarcroft Lane Laurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months 1₩ 2□ F Yrs 74 June 24, 1924 Director Washington, D.Q 577-28-6098 Usual Residence of Decedent the Meryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits Peges 1 end 2 should be filed within 72 hours efter deeth with the Merylen nent of Health and Mentel Hygiene. Inter if Item 27 is merked other then "natural", or items 23s or 28s-1 show ary or other treumsite event, the Medical Exercitor Foursities and all and a second of the secon 1 Yes 2 No Director Md. Prince George's Laurel 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 9000 Briarcroft Lane #320 20708 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 XXes 2 □ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1□ Yes XX No altimore. Maryland 21215-0020 Specify: þ 3 Widowed 4 Divorced WW2 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Grade 10 Route Salesman Commercial Laundry 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Clark H. Packard Sally Noakes 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. informent's Name/Reletionship (Type, Print) 3388 Crumpton S. Laurel, Maryland 20724 Leo Packard brother 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete permit. Peges
Department of
Important: If It
any Injury or c 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 4/16/99 Co. 22. Name and Address of Fecility Donaldson Funeral Home, P.A. 4/16/99 Catonsville, Md. 21. Signeture of Funeral Servica Licensee 313 Talbott Avenue Laurel, Maryland 20707 Approximete Interval Between Onset end Deeth 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or healt feilure. List only one cause on each line. **Physician** immediete Ceuse (Final disease or condition resulting in death) /Medical Metastatic Adenocarcinoma of Gall Bladder 4 months Examine Due to (or es e consequenca of): Examiner sicien end buriel-transit certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury Due to (or es e consequença of) Box 68760. physicien s the burie Physician/Medicai that initieted events resulting in death) Lest Due to (or es e consequence of) Se use ō 23b. Did tobacco uee contribute to the cause of death? P.O. ed by the deteched 1 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 1 ☐ Yes 2 ☐ No 3 Probably Duknown signed t Hypertension Records, þ 24b. Were eutopsy findings eveilable prior fo completion of cause of deeth? Completed 24a. Wes en autopsy peed Hypercipidemia hes pege 2 1 Yes 2XXN0 1 ☐ Yes XX No certificate Division of Vital or Attending Physician: funeral director, 25. Wes case referred to medical exeminer? Be 26. Piece of Death (Check only one) Other: 4□ Nursing Home XX Residenca 6 □ Other (Specify) 1 ☐ Yes XX No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this 28e. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Neturei 2 Accident 5 Pending efter death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homlcide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner steted. 29a. Certifier edicai To the Hosp within 24 ho To the Fune completely f (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signeture end title of antifier 29c. License number 2 D25422 April 16, 1999 1241 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 13952 Baltimore Avenue Laurel, Maryland Robert Maggin, MD 31. Dete filed (Month, Dey, Yeer) 32. Registras's Signature 6 1999 Registrar APR

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Deeth 3 Time of Death Month **Physician** MAY POWELL. /Medical 4c. County of Deeth 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street end number) Examiner WASHINGTON ADVENTIST HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) TAKOMA PARK MONTGOMERY CO. 9. Birthplece (Stete or Foreign 5. Social Security Numbar 6. Sax 7. Age (In yrs. lest birthday) **Funeral** 1□M 20 F Months 216-23-8413 Yrs. Director TRÍNIDAD Usuel Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar most be notified at 1 X Yes 2 □ No MD SILVER SPRING Director 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 20910 818 GIST AVENUE U.S.A.

14. Rece - Amaricen Indlen,
Black, White, etc. Funeral 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiena. Important: If fem 27 is marked other than "natural", or fear any Injury or other traumatic evant. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ZNo Specify: BLACK Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 5th HOUSEWIFE N/A 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be GEORGE LEVI UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) KENNY TURNER - GRANDSON 818 GIST AVENUE, SILVER SPRING, MD 20910 20b. Piace of Disposition (Name of cematary, crametory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GATES OF HEAVEN 16-99 SILVER SPRING, MD TANATION Address of FacilitiERAL HOME NORTH CAPITOL ST., NW WASH.DC 20001 23a. Pent1. Enter the disease, or communations that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart fellure. List only one cause on each line. Approximeta fntervel Between Onset and Death **Physician** Cardio Pulmonary fmmediete Cause (Finel diseese or condition resulting in death) /Medical Arres Examiner Examiner rrythmia burial-transit and Sequentielly list conditions, if eny, leeding to Immadiate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest Due to (or e) a consequance of): physician a Box 68760, Physician/Medical Dua to (or es e consequence of): 80 signed by the a Pert ff. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveilabla prior to completion of cause of death? 24e. Wes en autopsy performed? Completed 1 ☐ Yes 2 No 1 Yes 2 No After this certificata Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☑ DOA 1 Yes 2 No 2 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attanding PI
 24 hours effer death.
 Funeral Director: After th Certification: 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours e To the Funeral D edical 29e. Certifier Ecritifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of axamination end/or investigetion, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner steted. 29b. Signature and titla of certifiar 29c. License number 29d. Data signed (Month, Dey, Year) 036980. 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) University West Blud 113

32. Registrer's signatu

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 0912 APRIL 14 1999 4c. County of Deeth 1999 GILFRED C. PRINCE, SR. 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth PRINCE GEORGES 2108 QUEENS RAINER CHAPEL ROAD MOUNT If Under Months 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) Washington, D.C. 5. Sociel Security Number 1 M 2□ F Hours 1952 578-66-3689 46 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 11 Yes 2 □ No Maryland PRINCE GEORGES Hyattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20782 2108 Queens Chapel Road U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1971 14 Yes 2 No If Yes, Give Year or Dates: 1983 11 Meritel Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1971 Bleck, White, etc. 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black. 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Private 2yrs Truck Driver 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Sarah C. Cuthbertson Charles E. Prince 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 2108 Queens Chapel Road, Hyattsville, Maryland 20782 Rosalyn Prince/Wife 20b. Piece of Disposition (Name of cemetery, cremetory or other place) Dete 04/20 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State Ovantico National Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 1999 Quantico, Virginia 22. Name end Address of Fecility
J.B. JENKINS FUNERAL HOME 21. Signeture of Funeral Service Licenses 7474 LANDOVER ROAD, LANDOVER, MARYLAND 20785 Percen Vamou 23a. Pert1. Enter the disease of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Death Immediate Cause (Finel disease or condition resulting in deeth) CANCER OF THROAT & LUNG Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 CUnknown 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? 2 X No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Deeth

1 Natural

2 Accident 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner physicien end the buriel-transit The law requires that the deeth certificate be executed 80 for use es by the e signed t should I hes 9 page certificate Physician: this death. Director: / efter

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/Medical

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Funeral

Director

"natural", or items 23a or 28a-f ahow

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Raltimore, Maryland 21215-0020

Records, P.O. Box 68760, Division of Vital Hospital or Attending 24 hours of Funeral Dietely filled in

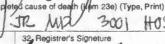
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State Registrar

GOLVE MARIO 31. Dete filed (Month, Dey, Year) APR 1 6 1999

29b. Signature and title, of dertifier

end eddress of person who com-



2 Medical Examiner: On the basis of exe end manner stated



1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s)

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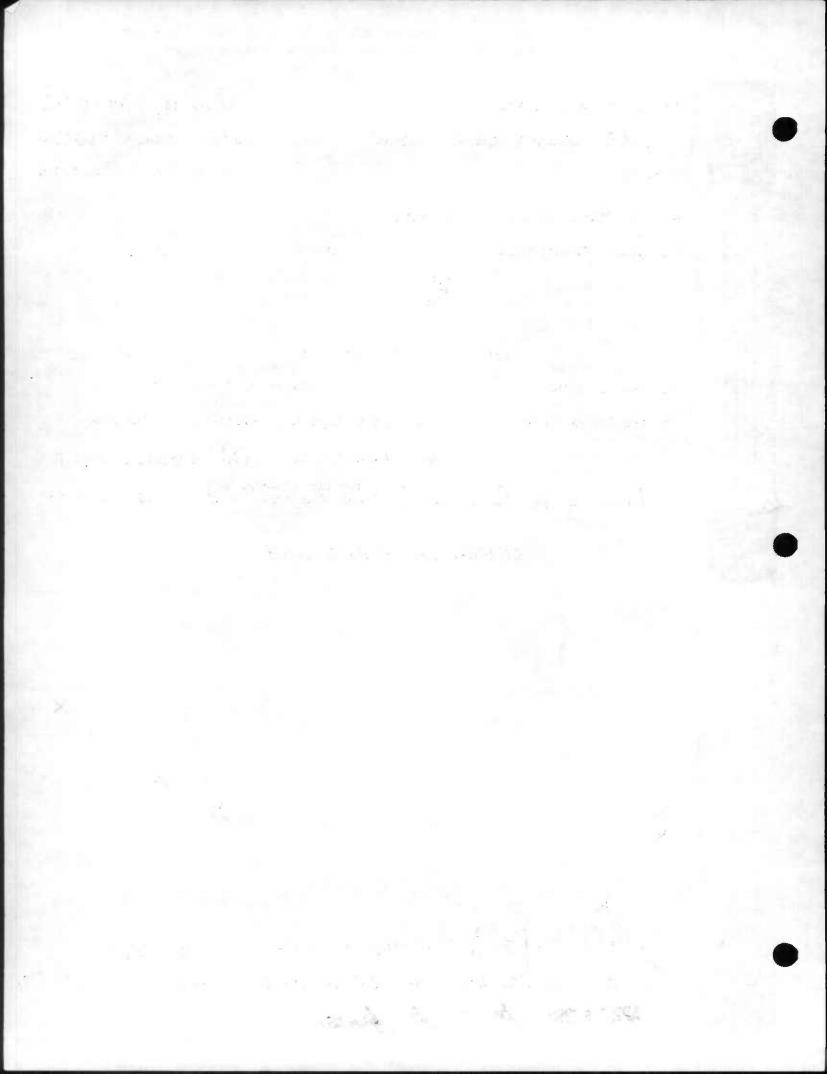
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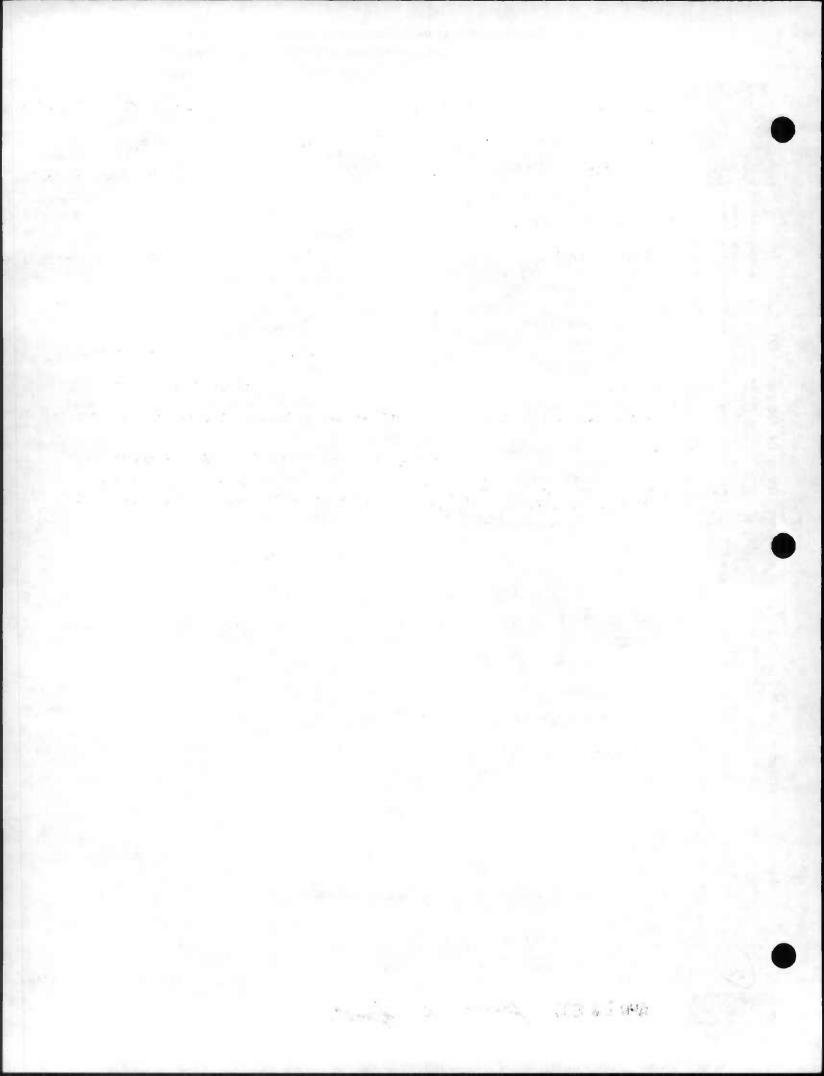
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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th with 23a or cast be	12916 - 7th St.			20720		United S	
- P - E - F	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U,\$ Armed Forces? 1 N Yes 2 No If Yes, Give		Hispenic Origin? (Specifiban, Mexicen, Puerto Ric	y Yes or No- an, etc.)	14. Race - Americ Black, White	an Indien.
o a		If Yes, Give Yeer or Detes:	1 ☐ Yes 2 🕅 No	Specify:		Specify: Ame	erican
I 21215-0020 led within 72 hours et ygiene "patural", or rt, the Modest Exam Completed by I	15. Decedent's Edu (Specify only highest grad	rcetion le completed)	16e. Decedent's Usual Occu (Give kind of work don	upation e during most of working ed)	16b.	Kind of Business/Ind	dustry
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Hiled Hygin	17. Father's Name (First, Middle, Last)		1441	18. Mother's Name (F	First, Middle, Maid		CITC
yland 2 ould be filed v Mentel Hygie arked other t antic event, tr	Leroy Pitts			Mat	tie Bell	Mosley	
Aar 2 sh and is m	19e. Informent's Name/Reletionship (7) Michael W. Pitt		19b. Meiling Address (Stree 9080L Moonsh				
or Healt Hem 21	20a. Method of Disposition		ace of Disposition (Neme of metery, cremetory or other pl	ace)	Dete 20c.	Location - City or To	wn, Stete
Page nent o	1 XBuriel 2 Cremetion 3 F 4 Donetion 5 Other (Specify)		rmony Memorial	Park 4/1	7/99	Landover,	MD
Baltimore, Normal Pages 1 and Department of Health Moortant: If Item 27 my Injury or other trans	21. Signature of Funeral Service Licens	00 A —	22. Name and Add	ress of Fecility St	ewart Fu	neral Hom	ie
W 80558	John T. Sl	ewarts, 111		nning Rd., N		n., D.C. 2	0019
Physician /Medical Examiner	23a. Pand. Enter the disease, or comb shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in deeth)	ne cause on each line.					Approximete the three Between Onset and Death
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that the detached by the detached	RECENT STI	ROKE WIT	H RIGHT F	IEM IPARESI	1 ☐ Yes	2□ No 3□ Proi	bably 4 Unknow
cords requires been sig should b	DIABETES	MELLITURS	,		24a. Wes en eu performed	? av	ere eutopsy findings eilable prior to mpletlon of ceuse deeth?
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Division of the or Attending P as after death, all Director: After 1 led in by the funers Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Day Year)	28b. Time of Injury M 1	ury at 286 ork?	d. Describe how Ir	jury occurred	
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To the Hospital or within 24 hours after to the Funeral Dir completely filled in Medical Cert	29a. Certifier 1 Certifying Phys	stclan: To the best of my know ner: On the basis of examineti end menner stated.					
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Division of Vital Records, P.O. Box 68760,

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State Registrar

29e. Certifier

(Check only one)

29b. Signeture and title of certifier

DME

29c. License number OCME 29d. Date signed (Month, Day, Year)

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30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)

218 FULFONDANE BEZAIN MD 21014 NABHUMD 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred et the tima, date end place, end due to the ceuse(s) and menner steted.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3 Time of Deeth Month Voor Patricia Houck Reid 1999 April 7:00am 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 5146 Homecoming Lane Columbia Howard If Under 1 Yaar | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpleca (Stete or Foreign Country) 1□ M 2XF Deys Hours 204-16-7777 Yrs. 75 Sept 23,1923 | Pennsylvania Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Howard Columbia 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5146 Homecoming Lane 21044 United States 12. Was Decadent Ever in U,S. Armed Forces? Wes Decadent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, Whita, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Nevar Married 28 Married 1 ☐ Yas 2 ☑ No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Δ Registered Nurse Healthcare 17. Fathar's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Austin J. Houck Gertrude M. Kline 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack A. Reid/Husband 5146 Homecoming Lane Columbia, Maryland 21044 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 4-10-99 Catonsville, MD 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. a 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disaasa, or complications that caused tha death. Do not enter tha mode of dying, such es cardiac or respiretory arrest, shock, or heer feilure. List only one ceuse on eech line. Approximete Intervel Betwaen Onset end Death Pulmonary Dirock Immedieta Cause (Final disease or condition resulting in death) Due to (or es e consequence of): Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequença of) Due to (or es e consequenca ol): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 Tes 2□ No 3 Probably 4 Unknown 24a. Was an eutopsy performed? 24b. Were eutopsy lindings eveileble prior to completion of cause of deeth? 1 Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case relerred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4☐ Nursing Home SK Residenca 8 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 5 Pending investigation Naturel

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-fahow

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should be filed within 72 hours effer on Mental Hygiene.

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permit. Page Department of Important: If any Injury or once.

Baltimore, Maryland 21215-0020

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siclan and bunal-trensit The law requires that the death certificate be executed Exami physiclan is the burial Physician/Medicai for ed by the a signed b þ page 2 should Completed certificate or Attending Physician: director, Be in 24 hours after death.
The Funeral Director: After this of the funeral director after this of the funeral director. P Certification:

Box 68760.

P.O. I

Records,

of Vital

Division

Hospital

within 2 the th

28c. Injury et Work?

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

29a. Certifier (Check only

2 Accident

3 Suicida

4 Homicide

29b. Signature end title of cartillier

1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of exemination end/or invastigation, in my opinion, death occurred et tha time, date end place, end due to the ceuse(s) end mannar stated.

29c. Licanse number

6 Could not ba

29d. Dete signed (Month, Day, Year)

30. Neme end eddress M erson who completed cause of deeth (Item 23e) (Type, Print)

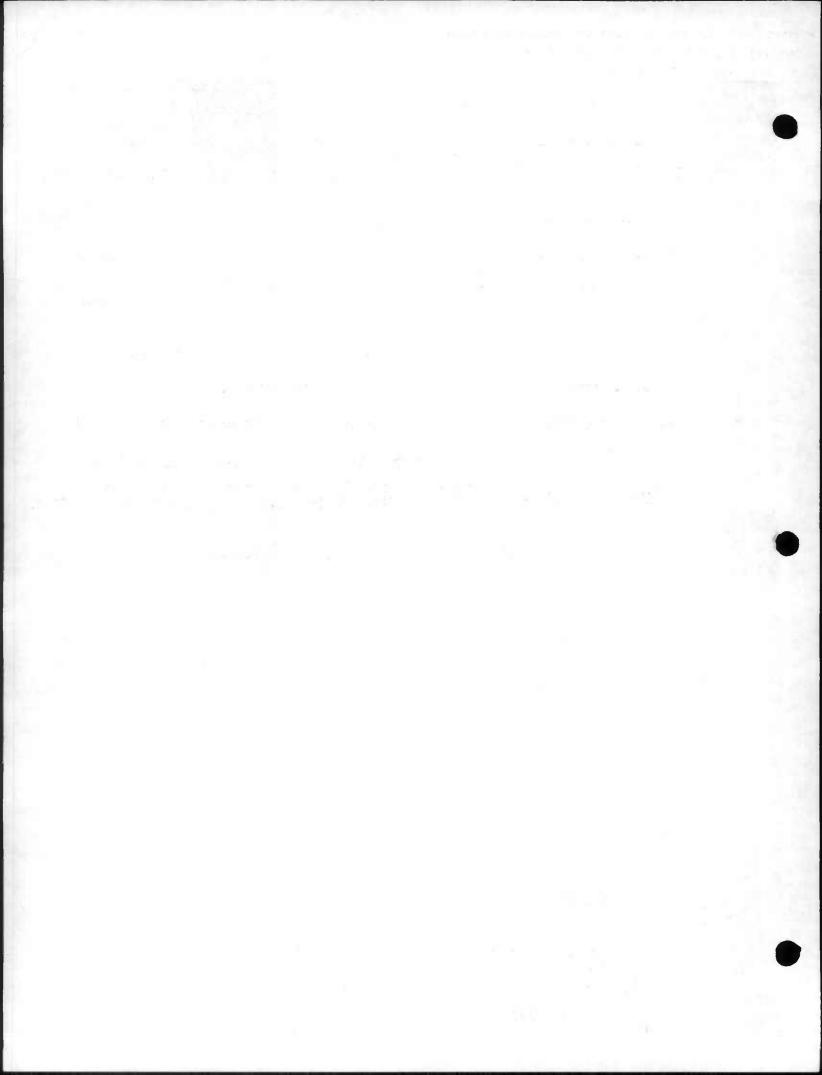
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bia, MD 21045 Marquerite Summers, MD

State Registrar

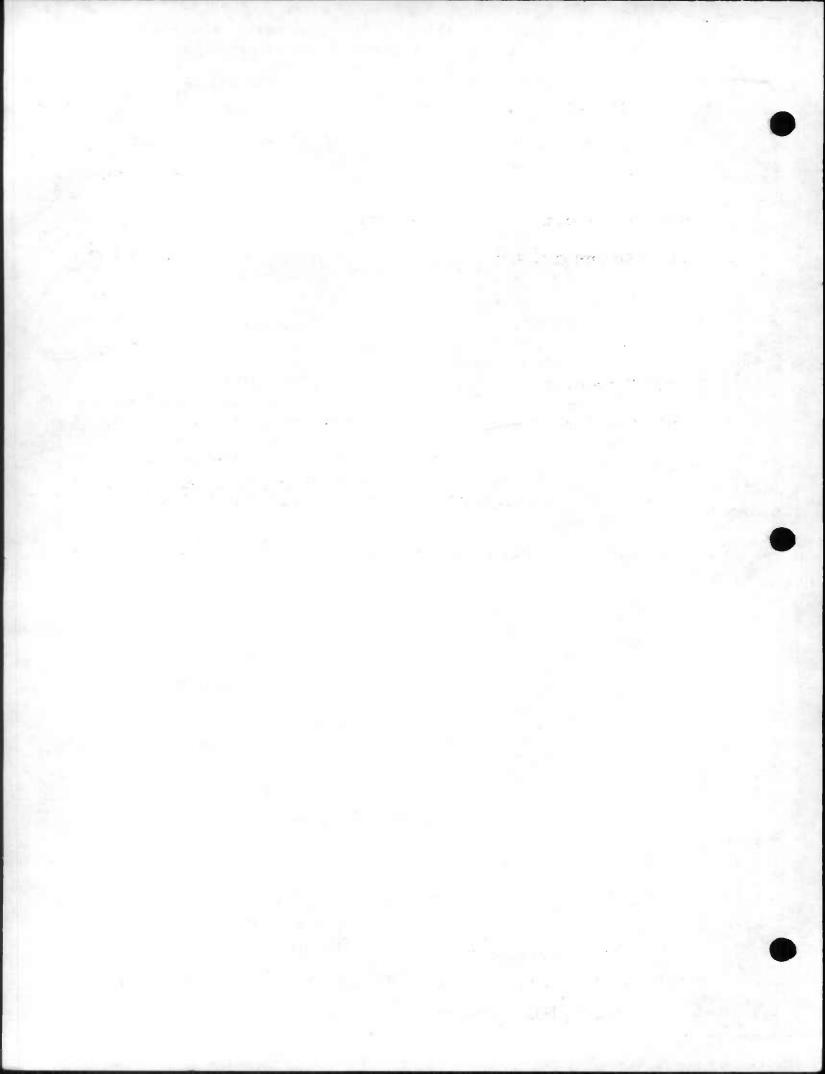
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31. Dete liled (Month, Day, Year) 32. Registraris Signeture 1999 APR 0



State of Maryland / Department of Health and Mental Hygiene

			(Certificate of	Death	Re	g. No.	14	102
61	1. Decedent's Name (First, Middle, Last)					2. Dete of Deet Month	h	(eer	3. Time of Death
Physician /Medical	Eleanor	L.	Riley			April		999	3:25am
Examiner	4a Facility Nama (If not institution, give s	treet and number)			4b. City, Town, or L	ocation of Death	4c. County of	Death	
	5727 B Harpers Fam	n Road			Columbi		Howa	ırd	
Funeral	5. Sociel Security Number 6. Sex	7. Aga (h	n yrs. last birth	Months Devi		8. Dete of Birth (Month, Dey,	Year) §). Birthpled	e (Stete or Foreig
Director	212-05-1221	8	0 Yr	S		May 7,			land
pu .	Usual Rasidence of Decedent 10e. Stete 10b. County	10	c. City, Town	or Location				104	. Inside City Limit
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after deeth with the Menylan or items 23s or 28s-f show anylost coust be notified at y Funeral Director	5727 B Harpers Fam		-1-110	210		%-MN-	United		
hem hem		2. Was Decedent Eva Armed Forces?	r in U,S.	 Wes Decedent of If Yes, specify Cu 	ban, Mexican, Puarto	Rican, atc.)		Whita, ato	
urs aft	1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Yaar or Datas:		1 ☐ Yes 2 🖫 No	Specify:		Specify:	Whi	te
n 72 hours after deeth with the Meryland **netural*, or Herra 23a or 28e-f show sited Ensemble rought be notified a leted by Funeral Director	15. Decedent's Educ		16a D	ecedent's Usuel Occ	unation		16b. Kind of Busi		
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al Hygin other vent, Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Nem	e (First, Middle, M	Maiden Sumeme)		
d be fill the mutal H ed out	Edgar Plummer Roe				Edith Re				
semit. Peges 1 and 2 should be filed with the beamment of Health and Mental Hygiena. Important: if item 27 is marked other than my injury or other traumatic event, the Mince. To Be Comp	19e. Informent's Name/Reletionship (Type	na Print)	19b A	Meiling Address (Stree	et and Number or Ru	ral Route Number	City or Town St	tete Zin C	ode)
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Health Health em 27 I	20a. Mathod of Disposition	1:	20b. Place of D	Disposition (Neme of		r	20c. Location - Ci		
permit. Peges 1 an Department of Heal Important: if item 2 any Injury or other price.	1 ☐ Burial 2 ☐ Cremetion 3 ☐ R	emovel from Stete		crematory or other pi					
rume rlum	4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funerel Servica License		Metro	Crematory 22. Name and Add		4-8-99	Catonsvi	lie,	MD
Depariment of the sany in police.	Show a Col	Elin - W	tyle	4112 old	Witzke's Columbia	Pike Ell	icott Ci	Lty, I	MD 21043
	23a. Pert1. Enter the diseese, or complice shock, or heert feilure. List only on	e ceuse on each fine.	death. Do no	t enter the mode of dy	/ing, such as cardiac	or respiratory arra	ist,	In	pproximate itervel Between Insat and Death
Physician /Medical	Immediate Course (Final		-		11 17	,			
Examiner	Immediate Cause (Finel disease or condition resulting in deeth)	METASTAT	ic me	lenoma te	, the br	AIN & LI	ver	1	3 months
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end I-trar	Sequentially list conditions, if any, leeding to immediate	Due	e to (or as e co	nsequence of):				i	
be a iclen buris	Cause. Enter Underlying Ceuse (Disease or Injury							i	
rificate be avacuted no physicien and as the burial-transit	thet initieted events resulting in deeth) Last	Dua	to (or as a cor	nsequence of):				1	
2 2 5									
The law requires that the death certificate be assected aste has been signed by the attending physicien end page 2 should be detached for use as the burial-transit Completed by Physician/Medical Exami									
the de ched	Pert II. Other significant conditions con	ributing to death but n	of resulting in t	he underlying cause (iven in Pert I.	23b. Dld to	bacco uae contr		
that the led by the detachery						1 V	8 2 No 3	□ Probal	bly 4 Unkne
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requires						perform		availe	eble prior to pletion of cause
has b								of de	eth?
ystclan: The L s certificate ha director, page To Be Com						1 □ Ye	s 2 XNo	101	Yes 2□ No
certificate rector, pag	25. Wes case referred to medical examiner?			1.		th (Check only on	Θ)		
Physician: this certific ral director. TO Be	1 ☐ Yes 2X No	ospitel: 1 Inpatient		atient 3 DOA	ther: 4 Nursing H	ome 🕉 Raside	nce 6 Othar	(Specify)	
Ter if	27. Menner of Death 1 ☑ Neturel 5 ☐ Pending	28a. Dete of Injury (Month, Dey Ye	ear) 28b. Tin		ury et ork?	28d. Describe ho	w injury occurred	1	
Arrending or death. ector: After by the fune iffication	2 ☐ Accident investigation			M 1	Yes 2 No				
after de Directe Jin by t	3 Suicide 6 Could not be determined	28a. Place of Injury building, etc. (5	At home, fam	n, street, factory, office	Э	28f. Location (St City or Town		or Rurel F	Route Number,
Cert Cert									
To the Hospital or Attending Pri- within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	29e. Certifier (Check only one) 1 Certifying Physical Certifician Physical Physical Phys	clan: To the best of m er: On the basis of exa end menner steted	aminetion and/	deeth occurred et the or investigation, in my	time, date end plece, opinion, deeth occur	end due to the cared et the time, de	tuse(s) end ment ete end plece, an	ner es stet d due to ti	ed. ne ceuse(s)
Me dithin	29b. Signatura and title of certifier			29c. Lice	nse number	2	9d. Date signed ((Month, De	sy, Year)
P 5 P 0	> M. L. (()	dulation	6	D3	38509		Anri	1. 8,	1999
16	30 Name and address of	child on the state of the state	/Hom 72-1 /**		-009		* 1 ./- 1-	01	
10	30. Neme and eddress of person who con Nicholas W. Koutpel	A XX 1106	5 Little	Patuxent	Pruj Co	unchin r	ois an	44	
State Registrar	31. Dete filed (Month, Dey, Year)	32. Registrer's		6. Inc.					



· Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Death Month April 13,1999 GERTRUDE A. ROZZEL 3:20PM 4b. City. Town, or Location of Deeth 4a. Facility Name (If not institution, giva street end number) 4c. County of Deeth DOCTORS HOSPITAL PRINCE GEORGES LANHAM If Under 1 Year | If Under 24 Hrs.
Months | Deys | Hours | Min. 5. Sociel Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Steta or Foraign
Country) 1□M 20 F December 21, 1947 West Virginia 51 Yrs. 235-80-0363 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 1 Yes 2 □ No Maryland Prince Georges Landover 10e. Street end Numbar 10f. Zip Code 10a. Citizan of What Country? 20785 7406 Goodland Drive U.S.A. 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) 2yrs Federal Government Secretary 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Douglas Rozzel Alberta (Unknown) 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) William T. Bryant/Husband 7406 Goodland Drive, Landover, Maryland 20785 20b. Plece of Disposition (Name of cemetery, crematory or other place) Data 04/17 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Glenwood Cemetery 1999 Washington, D.C. 21. Signeture of Funeral Service Licenses J.B. JENKINS FUNERAL HOME Nancu 7474 LANDOVER ROAD, LANDOVER, MARYLAND 20785 Ter cen he 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequance of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24e. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1/3 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how Injury occurred

physiclan end the burial-transit Box 68760, Physician/Medicai the Records, P.O. à Completed Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, Certification: To

Physician /Medical

Examiner

Physician

/Medical

Examiner

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permit. Pegas 1 and 2 should be filed within 72 hours after deeth with the Maryla Deperment of Haalth end Mental Hygiene. Important: if item 27 is merked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified anone.

25. Was cese referred to medical exeminer? 1 Yes 2 No 27. Mennar of Deeth 28c. Injury at Work? 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Medicai 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date and place, and dua to the causa(s) and manner steled.

29c. Licansa number

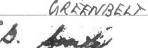
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29d. Data signed (Month, Day, Yeer)

31. Dete filed (Month, Dey, Year) APR 1 6 1999

29b. Signature and title of certifier

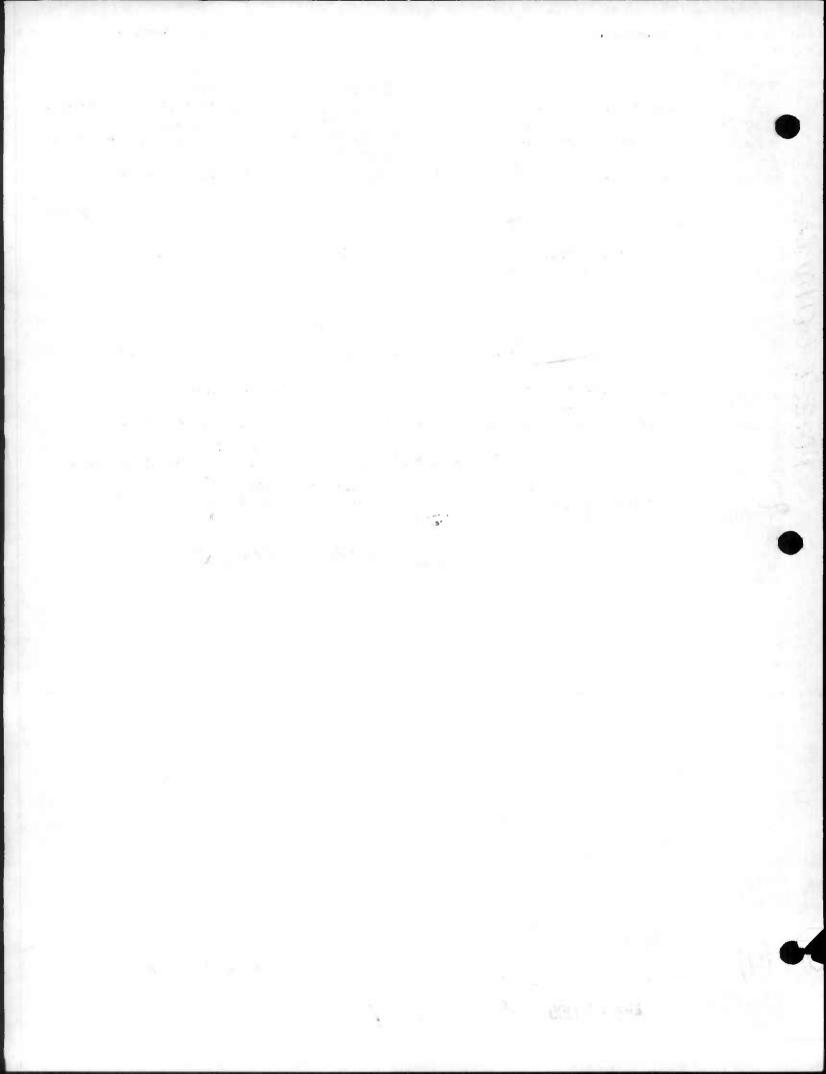
VXNKA PRAMAN NO 32 Registrar's Signature



30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 343 A MANOVER PORK WAY

DHMH 16 Rav 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31. Per Fitt. PGC 4-15-99 cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Day Louise (Janie) UNKNOWN Robinson April 12,1999 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3202 Amador Dr. Landover Prince Georges If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Birthplece (Stete or Foreign Country) **Funeral** Months Deys Hours Min. 225-10-4322D Director 95 Dec. 10, 1903 Virginia Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. tnslde City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No Md. Prince Georges Landover 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3202 Amador Dr. 20785 U.S.A. 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 20 No If Yes, Give 1 Yes No Specify: þ 3 Widowed 4 □ Divorced Specify: Black Year or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Retired Receptionist Dr. Office 8 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Horace Walker 2 Sally Parrish other traumatic 19e. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Louise Nelson (Daughter) 3202 Amador Dr., Landover, Md. 20785 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete permit. Pages Department of Important: If It any Injury or o 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from State 15/9 4 ☐ Donetion 5 ☐ Other (Specify) Lincoln Cemetery Suitland, Md. 22. Name end Address of Fecility Lewis Funeral Home 21. Signeture of Funeral Service Licensee 311 N. Patrick St., Alex., Va. 22314 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician Immediate Ceuse (Final diseese or condition resulting in deeth) /Medical CARDIOVASCULAR **Examiner** Examiner EREBROVASCULAR Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medicai Due to (or es e consequence of): for Pert it. Other significent conditione contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 2 No 3 Probably 4 Unknown by 8 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy 2 No 1 Yes Be 25. Wes cese referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attanding Physician:

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mentel Hygiene.

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Maryland 21215-0020

Baltimore,

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To the Funeral Director: To the Hospital of within 24 hours e To the Funeral D

State

Registrar

Medicai

DUBUISI 31. Dete filed (Month, Day, Year) APR 15

(Check only one) 29h. Signature and title of ced

> ACHUFUS 32. Registrer's Signature

MD

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

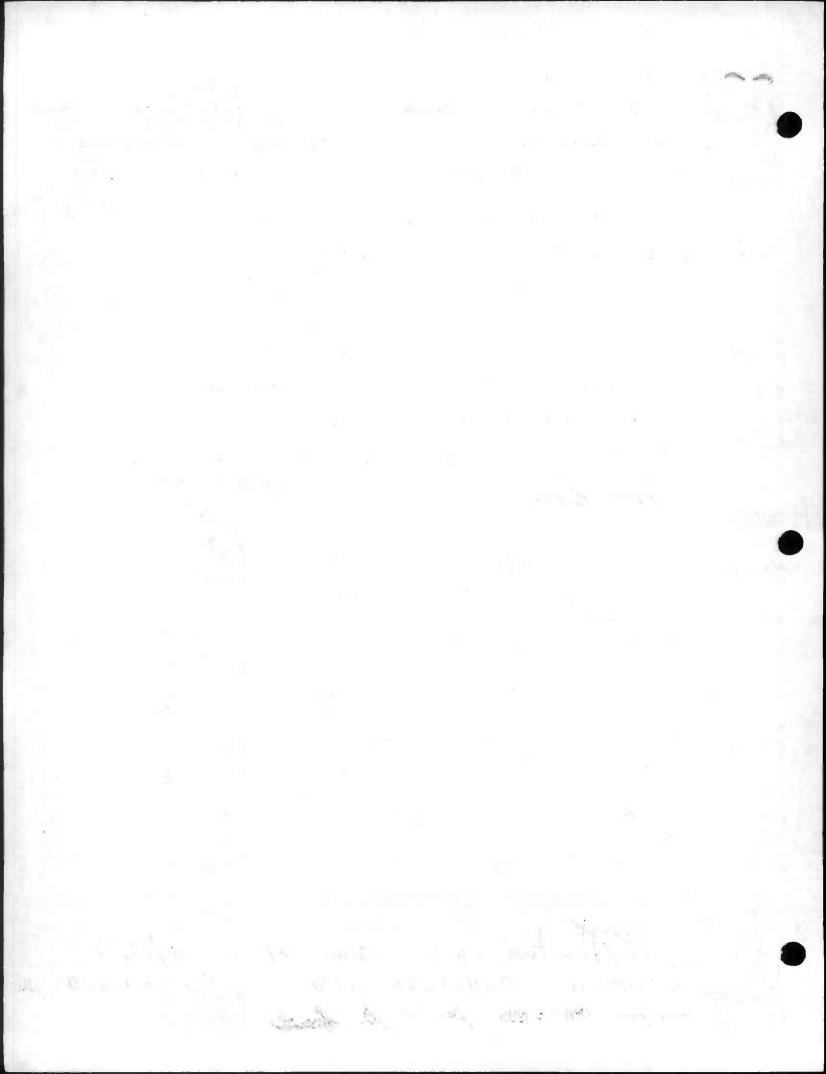
1 Certifying Physictan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted.

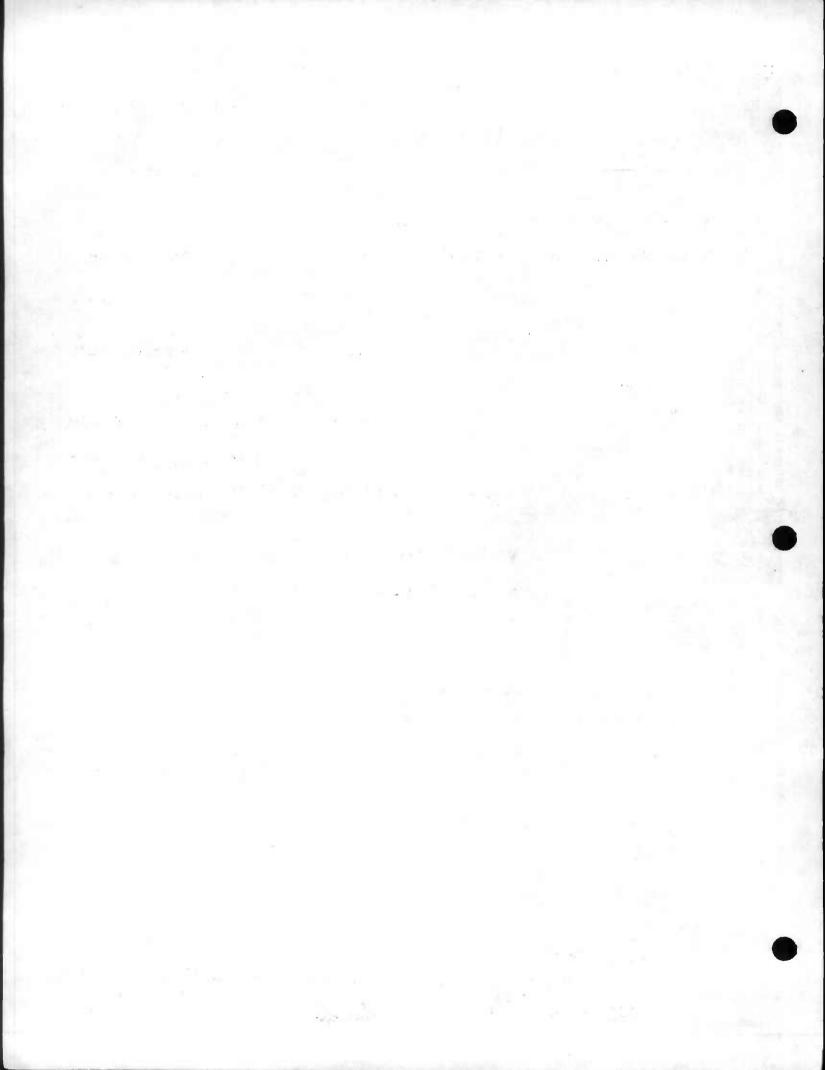
29c. License number

JOHNSON AVE, GLENDRIN, MD

29d. Date signed (Month, Dey, Yeer)



TEM: #5 PER	F.H. G772 6-28-99 WR.	State of Marylan	d / Department of Certificate of	Health and Mental H Death	Reg. No.	14.185
Physician /Medical Examiner	JEROME 4e Facility Nama (If not institution, give st		ROSCH	4b. City, Town, or Location of De	Day 9	199 10:43 Am
Funeral Director	003-09-4030	M 2 F 82		Hours Min. (Month,		9. Birtholace Stata or Foreign Country) New York
show date	Usual Residence of Decedent 10a. Stata 10b. County	10c. City	r, Town or Location			10d. Inside City Limits
recto	Maryland Montgomer	y Ro	ockville		10g. Citizen of Wh	1 ☐ Yes 2 ☑ No
traminer must be by Funeral Di	5901 Montrose Road, 11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	Apt. S1600 2. Was Decedent Evar in U, Armed Forces? 1 Yas 2/E No If Yes, Giva Year or Dates:	20852 S. 13. Was Decedent of	Hispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, etc.) Specify:	United No- 14. Race	States American Indian, White, etc.
Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usual Occu (Giva kind of work done lifa. DO NOT use retin	during most of working	16b. Kind of Busi	
8	12 17. Father's Nama (First, Middle, Last)	2 years	Treasurer	18. Mother's Nama (First, Mick		ng Studio
5	(Unknown) 19a. Informant's Name/Relationship (Typ)	e, Print)	19b. Mailing Addrass (Stree	Ida Brown t and Number or Rural Route Nu	mber, City or Town, S	tata, Zip Code)
	Steven Rosch-Son 20a. Method of Disposition	20b. P	6691 Macbeth lace of Disposition (Nama of	Way, Eldersbu	rg, Maryla	
	1 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from Stata	t Lincoln Ceme		Brentwoo	d, Maryland
	21. Signature of Funeral Service Licensed		22. Nama and Addr			
by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	ACUTE O	ras a consequence of): TELOGEN ras e consequence of):	ions LEUK	ENTA	Onset and Death 11 clays
Physic	Part II. Other significant conditions control	ibuting to death but not resu	liting in tha undarlying cause g	411		ribute to the cause of death? 3 Probably 4 Unknown
Completed by	Thronby you	<u>เลาเน้</u>		24a. W	as an autopsy enformed?	24b. Were autopsy findings available prior to completion of cause of death?
Com				11	Yes 20(No	1 ☐ Yes 2 ☐ No
To Be	25. Was case refarred to medical examiner? 1 Yes 2 No	spital: 1 Nnpatient 2 🗆	ER/Outpatient 3□ DOA O	26. Place of Death (Check on ther: 4 Nursing Homa 5 R		(Specify)
Certification: 7	27. Manner of Death 1 D(Natural 5 Pending investigation 3 Suicide 6 Could not be detarmined	28a. Data of Injury (Month, Day Year) 28e. Place of Injury - At ho	ma, farm, street, factory, office	Yes 2 No 28f. Locatio		d r or Rural Routa Number,
al Certi	29a. Certifier (X) Certifying Physic	building, etc. (Specify	viedge, daath occurred at tha t	City or ima, data and place, and due to t		
Medical	ane)	er: On the basis of examinat and manner stated.		opinion, death occurred at the tin	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ESONAIN SSSS
	29b. Signature and title of certifier	m MD	D45	5/2/	Agril 14	(Month, Day, Year)
	30. Name and address of person who don't Brick F. RET	PCMN Ke	23a) (Type, Print)	NEME; 1500	Forest G	le Aone
State istrar	31. Date filed (Month, Day, Year) APR 1 6 1999	32. Registrar's Signal	B. Louis		Silver 3	bring



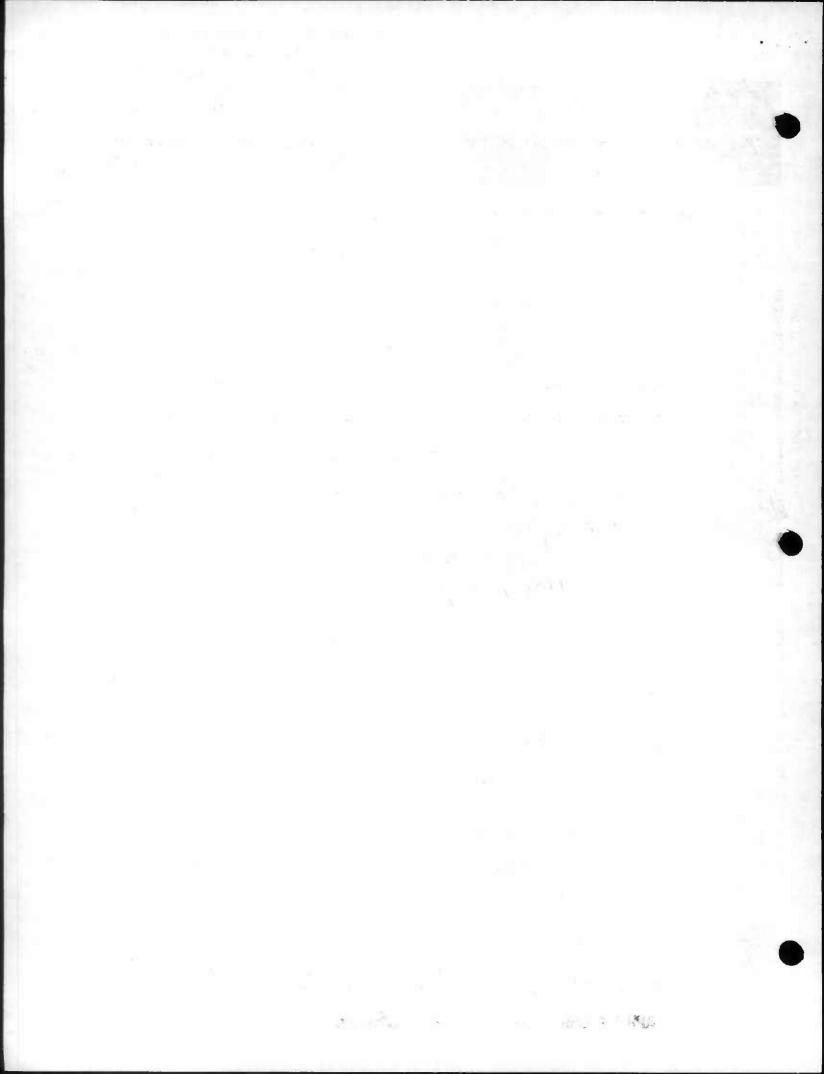
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ral or	MALCOLM G 5. Sociel Security Num 579-50-936	6. Sex		R e (In yrs. lest 77		Under 1 Year onths Deys	CAMP If Unde Hours	SPRI r 24 Hrs. Min.	8. Dete of B (Month, D DEC • 9	irth ley, Year)	9. Birth Cou	DRGE S plece (Stete or Foreign ntry) ILEY, VA
	Usuel Residence of De 10a. Stete 10	ecedent 0b. County		10c City T	own or Location	an .						10d. tnside City Limits
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To Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 3 🛣 Widowed 4 ☐	2 Married	12. Wes Decedent Armed Forces? 1 Yes 2 If Yes, Give Yeer or Detes:	Ever in U,S.		Decedent of I s, specify Cub Yes 2 XNo	Hispenic One an, Mexice Specify		ecify Yes or N Ricen, etc.)	o- 14. Rec Ble Specif	ck, White,	can Indien, , etc.
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edicai	29a. Certifier 1 (Check only one)	Certifying Phys Medicel Examin	cten: To the best of er: On the basis of end menner sta	exemination	dge, deeth occ end/or Investig	urred et the tingetion, in my o	me, dete er ppinion, de	nd plece, eth occurr	end due to the ed et the time	ceuse(s) end me, date end place,	enner es s end due t	steted. o the ceuse(s)
×	29b. Signeture end title	of certifier	byria			NC 35				29d. Date signe		
State	30. Neme and eddress ARTHUR J. 31. Dete filed (Month, D.	PATEFIEL	D, LT. CO		AF, MC	89 MD	G/105		PERIMET			

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Registrar

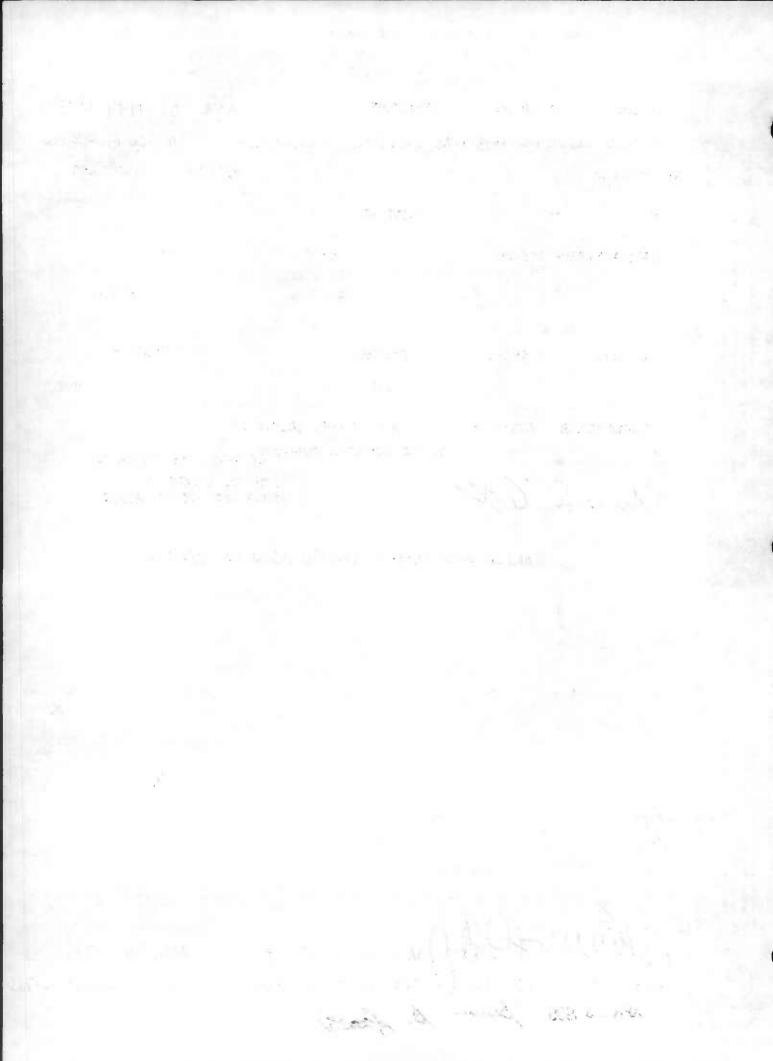
Baltimore, Maryland 21215-0020 NAME: OVELIA G REQUILMAN

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene

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ai Director	10e. Street end Numbe	LLSIDE A	AVENUE		10f. 2	Zip Code 207	785			0g. Citizen of V	Vhat Coun	try?
by runeral	3 ₩ Widowed 4 □		12. Was Decedent Armed Forces 1 Yes 2 If If Yes, Give Yeer or Detes	No			Hispanic Origin? pen, Mexican, Pu Specify:	(Specify Yellerto Rican,	es or No- etc.)	Blac	e - America ck, White, e	etc.
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	19a. Informant's Name	A/Relationship (T	ype, Print)		19b. Mailing Addre	ess (Stree	t and Number or	Rural Rout	e Number,	City or Town,	Stete, Zip	Code)
5	THOMAS	TYLER	(GODSON)		SAME AS	S 10A	A,B,C,D,	E,&F				
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State Registrar 31. Date filed (Month, Day, Year)
APR 2 1 1999

32 Registrar's Signature

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898 2 1 1999 Same D. Aprecia

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Death Month **Physician** Louise T. Schulz April 1999 8:30am /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heartlands - 3004 North Ridge Road Ellicott City Howard If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) March 24,1901 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys 1□ M 2 F Hours 437-10-1895 98 Louisiana Director Usuel Residence of Decedent 10d. Inside City Limits 10a. Stata 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23s or 28s-f shor the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3004 North Ridge Road 21043 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 25 No If Yes, Give Yaar or Dates; 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or Notif Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, atc. 72 hours after 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2K No Specify: Specify: ğ 3⊠ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Educetion (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiere. Important: If them 27 is marked other than "n any injury or other traumatic event the Med Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hame 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Arthur Tujaque Lea Claverie 2 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5041 Durham Road West Columbia, Maryland 21044 Lea Mae O'Donnell/Daughter 20e. Method of Disposition
1 □ Burial 2 □ Cremetion 3 □ Removel from Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 4 ☐ Donation 5 ☐ Other (Specify) 4-6-99 Metro Crematory Catonsville, MD 22. Neme and Address of Fecility
Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funeral Service Licensee llis ma Co 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Betw Onset and Death **Physician** Immedieta Cause (Final disease or condition resulting in death) /Medical 4 EARS ATHEROSCLEROTIC CARDIOVASCULAR Examiner Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, teeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequence of) Box 68760, Physician/Medical Due to (or es e consequence of): 98 980 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Tunknown DIAGERES Division of Vital Records, p 24b. Were sutopsy findings eveileble prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? - has page 2 1 Yes 2 XNo 1 □ Yes 2 □ No certificate Be 25. Wes case referred to medical 26. Place of Deeth (Check only ona) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2⊠ No this 28a. Data of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funera Certification: 28c. Injury st Work? After 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 ☐ Homicida Certifying Physician: To the best of my knowledge, death occurred et the time, data and place, and due to the cause(s) and mennar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and mennar stated. edical 29a. Certifier (Check only one) 29b. Signeture and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51860 - MD 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 3460 CIR DA # 103 ELLICUT (1979 . ELLICOTT ND 21043 JONATHAN FISH

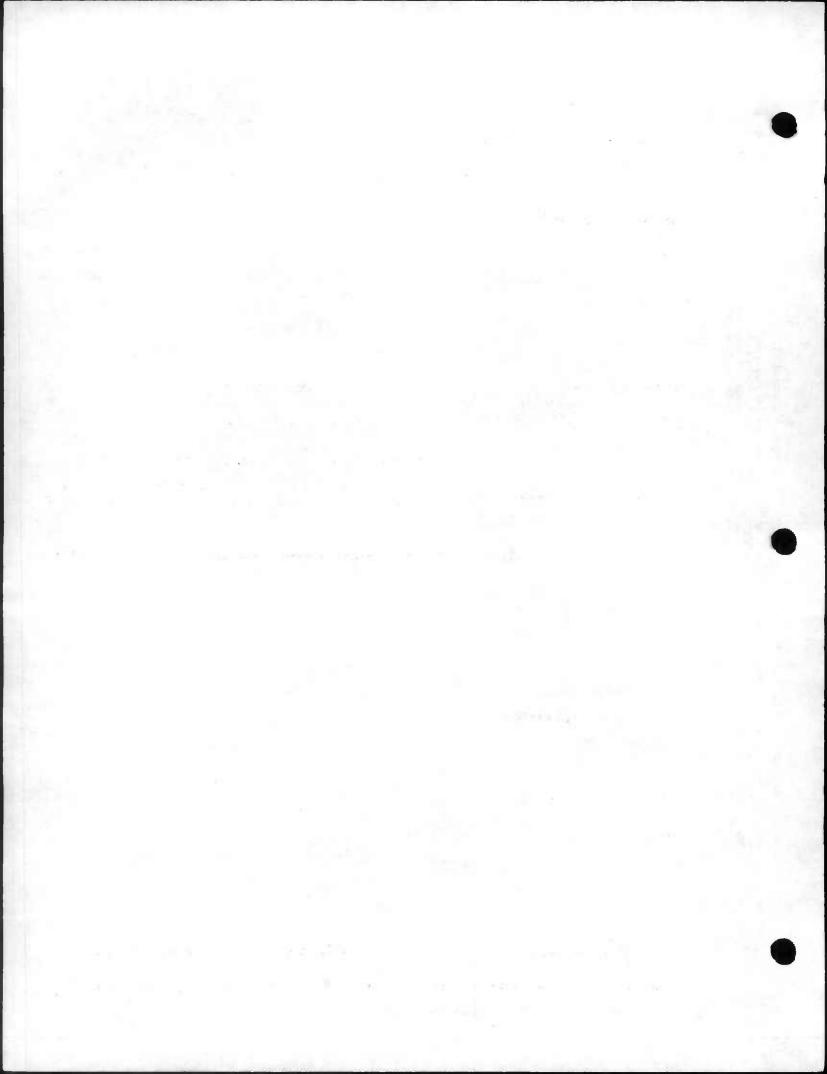
State Registrar 31. Dete fited (Month, Day, Year)

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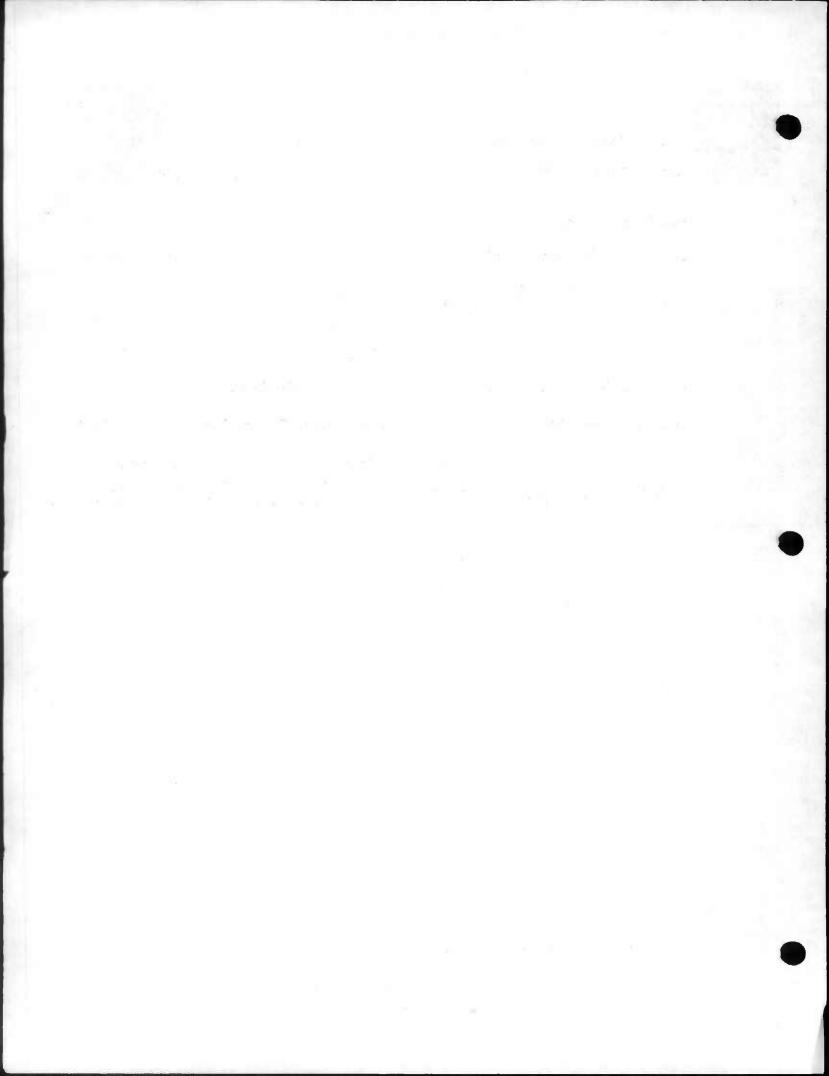
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32. Registrar's Signature

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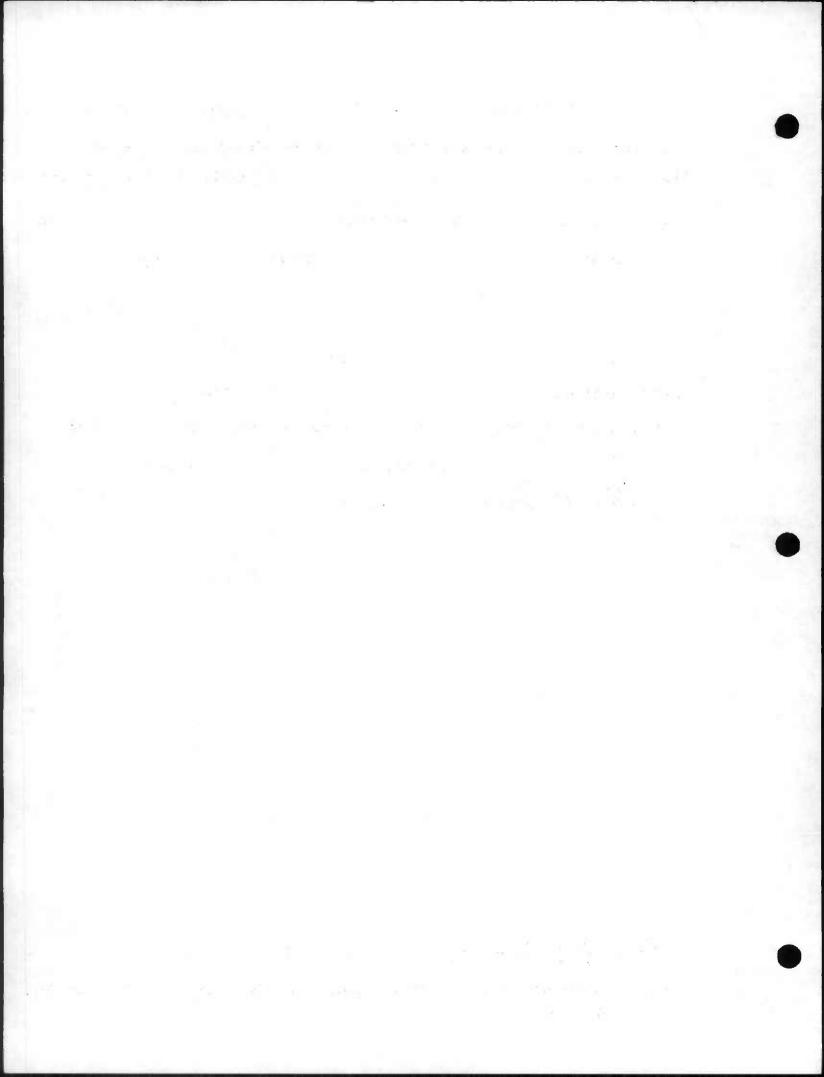


				State o	f Maryla		ertificate of		ind Ment	91	eg. No.		1190	
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	Funeral Director		5. Sociel Security Number 521–52–0657	6. Sex 1. 3 M 2 □ F	7. Age (In yrs	lest birthday Yrs.) If Under 1 Yea Months Dey:	r If Under 2	Min. (A	ate of Birth Month, Dey,	Year)	Coun	lece (Stete or Foreig try) Orado	חן
٠	and w		Usuel Residence of Decedent 10e. Stete 10b. County		10c. C	ity, Town or L	ocation						Od. Inside City Limits	
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020	or Its	by Funeral Director	11. Marital Stetus 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo	2 🗆 No		Wes Decedent of If Yes, specify Cu 1 ☐ Yes 2 🖫 No		jin? (Specify \ Puerto Rican	res or No- i, etc.)		ce - America ck, White, e		
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lan	2 short end N is man		19a. Informent's Name/Relationsh	p (Type, Print)		19b. Mei	ling Address (Street	et end Number	r or Rural Rou	rte Number	City or Town	, Stete, Zip	Code)	
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Baltimore,	Peges nent of h nt: If Ite		1 ☐ Buriel 2 🖾 Cremetion		State		osition (Name of emetory or other pi	lece)	De		20c. Location			
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	n 24 hour n 24 hour ne Funera	edicai	29a. Certifier 1 Certifying (Check only one)	Phyeicien: To the caminer: On the ba and menn	sis of examine	owledge, dee etion end/or In	th occurred et the the threat	ime, date end opinion, death	pleca, end du n occurred et i	ue to the ce the time, da	euse(s) end mate end placa,	enner es ste and due to	eted. the ceuse(s)	
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State of Maryland / Department of Health and Mental Hygiene

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D	e filed within al Hygiene. I other than vent, the Me		17. Fether's Neme)		110	MICHIA	rvet_	18. Mother's Ne	me (First, Middle	, Meiden Sumer	n <i>e)</i>		
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	/Medical Examiner		Immediate Cause disease or condition resulting in deeth)	(Finei in	e. Chron	nic Ob	struct	tive	Puln	onary D	isease			years	5
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20	or Attending effer deeth. Director: After In by the fune	Certification:	3 Suicide	6 Could not b	e ogo Diogo of Inju	ury - At hom	e, ferm, stre	et, fectory	, office		28f. Location (Street end Numi	ber or Rura	l Route Nu	ımber.
5	or A effer Direct	ert	4 Homicide	dotominod	building, etc	(Specify)					City or To	wn, Stete)			•
	To the Hospital or Attending Phi within 24 hours efter deeth. To the Funeral Director: After thi completely filled in by the funeral	edicai C	29a. Certifier (Check only one)	1☑ Certifying Ph 2☐ Medical Exar	nysician: To the best onliner; On the besis of	examinetio	edge, deeth n end/or inve	occurred e	et the tim in my op	e, dete end pleci inion, deeth occ	s, end due to the urred et the time,	cause(s) end modate end plece,	enner es st	eted.	o(s)
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	3				completed cause of d				_			,			
			Peter L. 31. Dete filed (Mont	WISNIEW	ski, M.D.,	110					10, Prin	ce_Fred	erick	, MD	20678
	Sta Registr			APR 15	1999	22 July 1	~	9	do	21/2/					



Direct

Physicia /Medic **Examin**

To the Hospital or Attending Physician: The law requires that the death certificets be associated within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physician end complately filled in by the funeral director, page 2 should be deteched for use as the burlet-trensit

Division of Vital Records, P.O. Box 68760,

WILLIAM JOSEPH STEEGER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

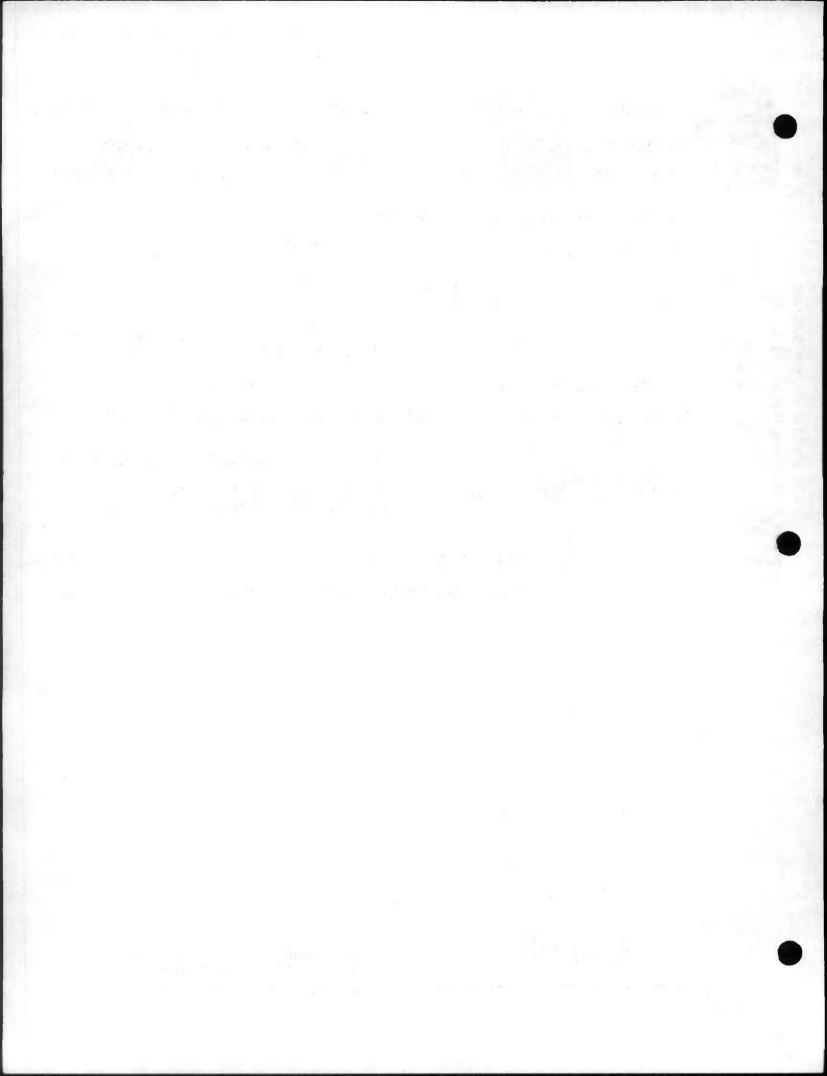
an :al	ויי	Decedant's Nama (First, Middla, Last					2. Data of De Month	Day	Yaer 3.	
d		WILLIAM	JOSEPH	S	TEEGER			16 1999		:50 A.M.
er	-	4a. Fecility Nama (If not institution, giva	street and number)			4b. City, Town, or	Location of Deet	h 4c. County	of Death	
		MALCOLM GROW MEDI	CAL CENTER			CAMP SPR	INGS	PRINCI	E GEORGI	E'S
		Social Sacurity Number 6. Sa		M	f Under 1 Year fonths Days		S. 8 Data of Bi	rth	9. Birtholace	(State or Foreign
		Usual Rasidance of Decedant	ØM 2□F 80	Yrs.	Days	riouis (viii	Jan. 2	8, 1919	South"(Carolina
tor	0	Maryland Charle		Waldor						nsida City Limits
by Funeral Director	2	10e. Street and Number			10f. Zip Coda	20601		10g. Citizan of \		
6	0	10372 Jewel Court						U.S.A		
nu	5	11. Marital Status	12. Was Decedant Evar in Armed Forcas?	U,S. 13. Was	s Decedant of F es, specify Cub	lispanic Origin? (an, Maxican, Pua	Specify Yes or No nto Rican, etc.)	- 14. Rad Blad	e - Amaricen In ck, Whita, etc.	dian,
DV F	, n	1 ☐ Never Merried 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	1 X Yas 2 □ No 1 If Yas, Giva Year or Datas: 1	938- 958	Yas 2 No	Specify:		Specify	"White	
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ge	מ	17. Fether's Name (First, Middla, Last) William Joseph	Stagger				oma (First, Middle arl Youn		ne)	
0	-	19a. tnformant's Name/Ralationship (T)		19h Mailing 4	Addrass (Street	end Number or F		3	State 7in Cod	(e)
		Thomas M. Steeger/	Son	10372	Jewel C	ourt, Wa			20601	7/
		20a. Mathod of Disposition 1 ☐ Burial 2 🕱 Cramation 3 ☐ F		b. Place of Disposition cematary, cramato	on (Neme of ory or other pla	сө)	Data	20c. Location -	City or Town, S	Sleta
		4 □ Donation 5 □ Othar (Spacify)		untt Crema	atory	04	-17-1999	Waldo	rf, Mar	yland
		21. Signature of Funeral Service Cicens	000	22. N	ama and Addra	ss of Facility	1 11	T		
		OUHN P. KNISLE	EY M0116			t Funera			00004	
-		23a. Pert1. Entar tha disaasa, or compl	lications that caused tha d	aath. Do not antar ti	ha moda of dvi	156, Wa	C or raspiratory a	Maryland		roximata
		shock, or heart failure. List only or	na causa on aach line.		,		,		tnta	rval Between set end Death
	۱	Immediata Causa (Final								
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ō	5		Due to	o (or as a consaquar	nca of):				1	
	Type			BSTRUCTIV		NARY DI	SEASE		30	YEARS
X		Sequantially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disaase or Injury	Dua to	o (or as a consaquen	nce of):				i	
10	1	Cause (Disaase or Injury thet initiated evants	c						i	
	3	rasulting in daath) Last	Dua to	o (or as e consaquan	ica of):					
CIAIL/Medical			d							
63	3									
_		Part II. Other significant conditions con	ntributing to death but not i	asulting in the under	rlying causa gi	van in Part I.	23b. Dtd	tobacco uae co	ntributa to the	cause of death?
_		Part II. Other significant conditions cor	ntributing to death but not	rasulting in tha unda	rlying causa gi	van in Part I.		tobacco uae co Yes 2□ No		
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_		Part II. Other significant conditions con	ntributing to death but not i	rasulting in tha unda	rlying causa gi	van In Part I.	1 X	Yes 2 No	3 Probably 24b. Wara ei	utopsy findings a prior to tion of causa
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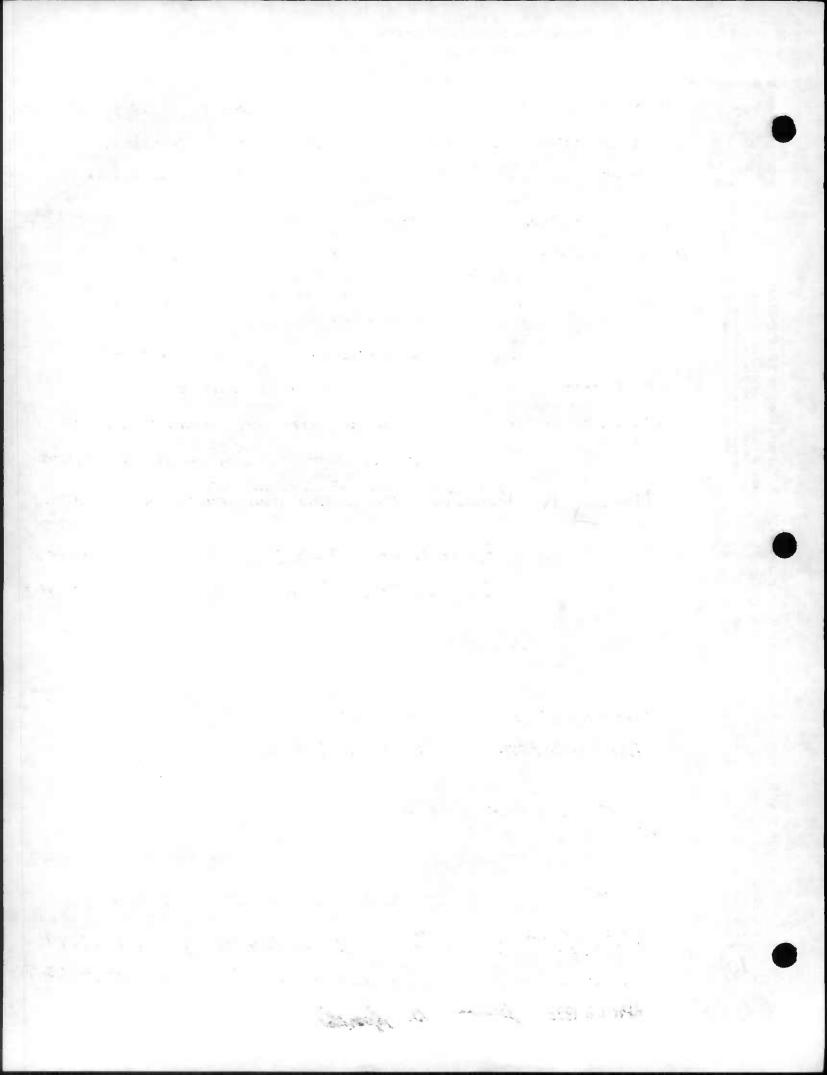
APR 2 0 1999

State

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Day Month **Physician** ALEASE WYNONA SCOTT APKI 4d. County of Death /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, giva street end number) **Examiner** WASHINGTON ADVENTIST HOSPITAL Takoma Park Montgomery If Under 1 Months I 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Hours **Funeral** Min. Days 1□M 20 F 66 Yrs. Director 092-28-1008 October 6, 1932 Hopewell, VA Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Wedest Exercited must be notified at DAR. 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Directo Maryland Prince Georges Springdale 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3609 Cousins Drive 20774 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Yeer or Detes: 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 HNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black. Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 2yrs Crypto Analyst Government 17. Fathar's Name (First, Middla, Last) 18 Mother's Name (First Middle Maiden Sumeme) Be Tamlin Pierson Larlie Madie Kee 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ira D. Scott/ Husband 3609 Cousins Drive, Springdale, Maryland 20774 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 04/16 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery Brentwood, Maryland 1999 22. Name end Address of Fecility 21 Signeture of Funeret Sarvice Licenses J.B. JENKINS FUNERAL HOME Nancu Verca 7474 Landover Road, Landover, Maryland 20785 23e. Pert1. Enter the disease or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. Est only one cause on each line. Approximete Intervel Between Onsat and Death **Physician** /Medicai Immediate Cause (Final RESPIRATORY FAILURE WEEKS disaesa or condition resulting in death) Examiner Examiner RHEUMATOLD YEARS physician and the buriel-transit that the death certificete be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): ettending p for use es 98 P.O. signed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No HIPERTENSION ; HYPOXEMIA Records, by The law requires 24b. Were eutopsy findings availeble prior to completion of cause of deeth? 24e. Wes en eutopsy Completed GASTROESOPHAGEAL REFLUX DISEASE has e 2 After this certificete ha funerel director, page 1□ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) Certification: 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending death. 1 ☐ Yes 2 ☐ No ie Hospital or Attendii n 24 hours efter death. ie Funeral Director: A bietely filled in by the fo investigation 2 Accident 6 ☐ Could not be 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only 2 Medical Examiner: On the basis of exemination and/or invastigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end menner stated. 29b. Signature and title of certifier 29d. Date signad (Month, Dey, Year) 29c. Licanse number 22549 Mon 10 Kenilworth Ave, Riverdale M.D. 2073; 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) M. DIN M.D 31. Dete filed (Month, Dey, Year)
APR 1 3 1999 32 Registrar's Signature State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Vijene. 14. De Med cal Examiner must be notified at Compieted by Funeral Director	11. Me	rital Status Never Marrie Widowed 4		rried	12. Was Dec Armed For 1 Tyes If Yes, Gi Yeer or D	orces? 2 💢 No ive	r in U,S.		es Decedent of es, specify Co			ecify Yes or Rican, etc.)	No-		a - America ik, White, e : Bla	tc.	
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eith e 27 is ar tra	J	uanita	Benja	amin	/Daugh	nter	3	07 -	69th P	lace,	Seat	Plea	sant	t, Mar	yland	207	43
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

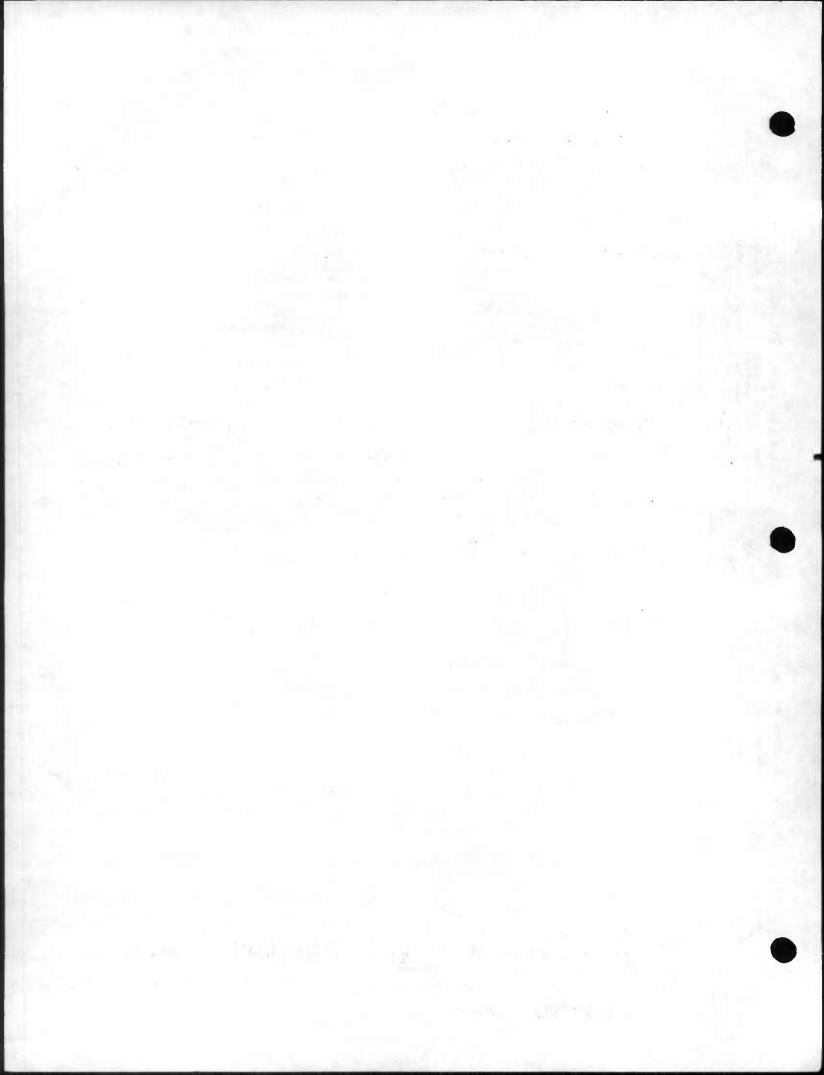
_		Certificate	of Death	Reg. No.	14/95
н	Physician	1. Decedent's Nama (First, Middle, Last)		Data of Death Month Day	3. Tima of Death
Л	Medical	DEDTHA IFAMETTE CMITH		RIL 9 1999	
	Examiner	4e Facility Name (If not institution, give street and number)	4b. City, Town, or Location	on of Death 4c. County	of Death
П		FORT WASHINGTON HOSPITAL	FORT WASHIN	GTON PRING	CE GEORGE'S
Г	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Year If Under 24 Hrs. 8.1 Days Hours Min.		
L	Director	244-02-0721 1 M 201 36 Yrs. Months 1 Usual Residence of Decedent	NO NO	Data of Birth (Month, Day, Year) VEMBER 6,196	2 WILSON, N.C.
	death with the Meryland me 23e or 28e-f show rment be notified at	10a. State 10b. County 10c. City, Town or Location			10d. Insida City Limits 1 ☒ Yas 2 ☐ No
	or 28e-f a	MARYLAND PRINCE GEORGE'S TEMPLE HILLS		09100	
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21215-0020	urs effer alf, or he harmon	3 ☐ Widowed 4 ☐ Divorced	nt of Hispanic Origin? (Specify Cuban, Mexican, Puerto Rica No Specify:		e - Amarican Indian, ck, Whita, atc. V: BLACK
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21	within 7	(Specify only highest grade completed) (Giva kind of work life. DO NOT use	done during most of working retired)		
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Maryland			Street and Number or Rural Re	outa Number, City or Town,	Stata, Zip Code)
		JOSEPH SMITH/ HUSBAND 4908 FOLEY	TERRACE TEMP	LE HILLS, MA	RYLAND 20748
6	te 1 and of Health Hem 27 other tr	20a. Method of Disposition 20b. Place of Disposition (Nama	of D		City or Town, Stata
ê.	A H: H	1 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Dogation 5 □ Other (Specify) REST HAVEN CE	(TIMEDAY	WILSON,	N.C.
Baltimore,	pemit. Pa Departmen Important: any injury.	21. Signature of Funeral Service Licensee 44.1.0 / 22. Nama and	Address of Facility		11.0.
B	Ped impo	ALEAANI	DER S. POPE FU		
		23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.			MARYLAND 20747 Approximata
x 68760,	ing physicien and a as the burist-transit Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	reost Car	ncer	
Box	that the death certified by the attending detached for use a Physiciar/Mc	0.			
0	by the tached	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	se given in Part I.	1 ☐ Yes 2 ☑ No	ontribute to the cause of death? 3 □ Probably 4 □ Unknown
s, P	oned be dete	bone Cancer Adonen Canc	er	T TOS ZIE NO	3 Probably 4 Onknown
Records,	The law requires that the death cent atte has been signed by the attending page 2 should be detached for use.	Multiorgan Cancer with for	ure	24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
Be	sician: The law certificate has billrector, page 2 s	Reas Cancer Breast Co.	100	1□ Yas 254No	1 ☐ Yas 2 ☐ No
Vital	edor, potor, Be C		26. Place of Death (C	<u>`</u>	
>	o di o		Other	5 ☐ Residence 6 ☐ Oth	ner (Snecify)
n of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification completely filled in by the funeral director. Medical Certification: To Be C			Describe how injury occur	
0	endi or: A	2 Accident investigation M	1 Yes 2 No		
Division	to a first death. In or Attending Paragraphs of the funer and in by the funer. Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, obuilding, etc. (Specify)	office 28f.	Location (Street and Numb City or Town, Stata)	per or Rural Routa Number,
0	De since of the si		the time date and alone and	due to the source(s) and m	enner as stated
	Ne Hospi n 24 houns Ne Funer plately fill	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.			
	Me the		icense number	29d. Date signe	ed (Month, Day, Year)
	-310	OMCOSKW M. O. O.	37066	04-	10-99
	(4)	20 Name and address of access who considered areas of the fire and the	37000		
	(1)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	140 + Old	Branch 1	Ave. #105
		31. Deta filed (Month, Day, Year)	enple Hill	s, mo 20	748
	State Registrar	APR 1 2 1999	زم		

Registrar

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	State of Marylan	d / Department of I Certificate of		Reg. No.	1.197
Physician /Medical	Decedent's Name (First, Middle, Last) Louise E. Garrison Via		2. Dete of Month April	Dey Year 6 1999	3. Time of Death 7:10am
Examiner	4e Facility Name (If not institution, give street end number) 2324 Washington Boulevard		4b. City, Town, or Location of De Baltimore		
Funeral Director	5. Social Security Number 6. Sex 1 □ M 2 F 7. Age (In yrs. In the second of the secon	last birthday) If Under 1 Year Months Days		Dey, Year) Co	hplece (Stete or Foreign untry) Cqinia
with the Maryland s or 28a-f show be notified at Director	Usual Residence of Decedent 10a. State 10b. County 10c. City Maryland None	y, Town or Location Baltimore			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
uth with the Ma 23e or 28e-f s wat be notified rai Director	10e. Street and Number 2324 Washington Boulevard	10f. Zip Code 21230)	10g. Citizen of What Co United Sta	
ter dos ter dos toer m	11. Merital Stetus 1 Never Merried 2 Merried 3 XWidowed 4 Divorced 12. Wes Decedent Ever in U, Armed Forces? 1 Yes 2 Xho If Yes, Give Yeer or Detes:	S. 13. Was Decedent of Hif Yes, specify Cub	dispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, etc.) Specify:	Snerity:	
Maryland 21215-0020 6 2 should be filed within 72 hours at the and Markat Hyglere. 7 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done lite. DO NOT use retire Homemaker	during most of working	16b. Kind of Business/	industry
yland Syland Syland Syland Mental Hyginsteed other effic event, I	17. Fether's Name (First, Middle, Last) Reuben Garrison		18. Mother's Neme (First, Midde Annie Shiffle	dle, Maiden Sumeme)	
CZNE	19a. Informent's Neme/Relationship (Type, Print) Lee R. Garrison/Son 20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3 ⊠Removat from State		Lane Severn, Ma		
Baltimore, permit Fages 1 a Department of Hes Important: If Item any Injury or othe	4 Donation 5 Other (Specify) 1. Signeture of Funeral Service Licensee	melstown Cemet	ss of Facility litzke's Family	Funeral Home	, Inc.
Physician /Medical Examiner	I resulting in death)	Do not enter the mode of dying the same of		y errest,	Approximate Interval Between Onset end Deeth
BOX 68/60, eath certificate be executed attending physician and for use as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last b. Due to (or	PHASIA res e consequence of):	ACCIDENT		
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aw request been 2 should	FALLS		24a. W		Were eutopsy findings evailable prior to completion of cause of death?
r Vital Reyysician: The lay ysician: The lay director, page 2 for Be Comp	25. Was case referred to medical examiner?		26. Place of Death (Check on		1 □ Yes ₽ØNo
To the Hospital or Attending Physician: To the Funcis after death. To the Funcis Director: After this certific completaly filled in by the funcial director, Medical Certification: To Be (1 Yes 2 No Hospital: 1 Inpatient 2 I 27. Manner of Death 1 Neturel 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At ho	me, farm, street, factory, office	ry at rk? Yes 2 No 28f. Location	ne how injury occurred In (Street and Number or Ru	
To the Hospital or within 24 hours afta within 24 hours afta To the Funeral Dirt completaly filled in Medical Cert	29e. Certifier (Check only one) 29e. Medicat Examiner: On the basis of examinat and menner steled.	wledge, death occurred et the ti	me, date and place, end due to the		
To the within 2 To the comple	29b. Signeture and title of certifier	29c. Licens	46 449	29d. Date signed (Month	
State Registrar	30. Name end address of person who completed cause of death (Item NOELLA MSQUITA 3L21 B 31. Date filed (Month, Dey, Year) APR 0 7 1999 32. Registrer's Signat	ENSON AVE, S	uiTE 230	BALTIMORE	MDQIQQA



Otata at Manufacial (D				0
State of Maryland /	Department	or Health	and	mentai	Hygiene

Certificate of Death 1 Decedent's Neme (First Middle Last) 2. Date of Deeth 3. Time of Death APRIL **Physician** MARY WOLFE E lizabeth 10.50M Π /Medicai 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner WESTERN MARYLAND HOSPITAL CENTER HAGERETOUN WATHINGTON 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 1 M 2 Months Deys Hours Director 234-60-3014 March 4, 1924 Maryland Usuel Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or items 23e or 28e-f show any Injury or other traumatic event, its Medical Exception made to notified as any injury or other traumatic event, its Medical Exception made to notified as 10d. Inside City Limits 1 X Yes 2 □ No Directo W. Va. Berkeley Martinsburg 10e. Streef end Number 10f. Zip Code 10g. Citizen of Whet Country? 206 Bernice Avenue 25401 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give ✓ Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. ρ 3 (Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coltege (1-4or 5+) Custodian Government 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Harry Jacob Ashbaugh Alice Marie Benger 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) John Mason Wolfe, Son 206 Bernice Avenue - Martinsburg, WV 25401 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Sfate 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/9/99 | Hillsboro, VA Hillsboro Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility Eackles-Spencer Funeral Home Harpers Ferry, WV 25425 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dylng, such as cardlec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical fmmediete Ceuse (Finel RESPIRATORY FAILURE diseese or condition resulting in deeth) Examiner RENAL FAILURE ettending physician and for use es the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initioted events resulfing in death) Lest FAILURE Box 68760 Physician/Medical Due to (or es e consequence of): STROKE SIP ADRTIC STENOSIS, SEVERE Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 | Yes 2 | No STROKE þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed DIABETES MELLITUS 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, i 8 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 2 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Neturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Plece of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the besis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to fine cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Yeer) 29b. Signeture end fitle of certifier 29c. License number APRIL 7TH 1999 Turbeld My 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Ian Newbold, M. D. - 1500 Pennsylvania Avenue - Hagerstown, MD 21740 32. Registrer Signetur

DHMH 16 Rev 6/95

State

Registrar

APR 0 8 1999

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State of Maryland / Department of Health and Mental Hygiene

				Certific	ate of	Death		1	Reg. No.		4122	
	1. Decedent's Nama (First, Mi	ddle, Last)						2. Date of Date	ath	V	3. Tima of Death	
Physician (Martine)		G	race Cla	ire Wh	iting			April	03, 19	99 ^{9ar}	10:55 A	M
/Medical Examiner	4a Facility Name (If not institu	tion, give street and number	er)			4b. City, To	wn, or Lo	cation of Daath	4c. Count	of Death		
	Laurel Region	al Hospital				Laure	21		Princ	ce Ge	orge	
Funeral	5. Social Security Number	6. Sex 7.	Age (In yrs. last bit	rthday) If Ui	nder 1 Year		24 Hrs. Min.	8. Date of Birt (Month, De			piaca (State or Forei	ign
Director	214-28-3948	1□M 2XF	81	Yrs.	ths Days	Hours	IVIII.	Sep 17	, 1917		Virginia	
P.	Usual Residence of Decedent		10- 0h T-							1.	0.1 1.11.05.11.1	**-
arylar show	10a. State 10b. Cou		10c. City, Tow	n or Location						1	0d. Inside City Limi 1 XYes 2 □ N	
Ba-f.	MD Anne	Arundel	Sever	n							ILA 165 Z	10
or 2	10e. Street and Number			10f	. Zip Code				10g. Citizen of	What Cour	ntry?	
United death with the Mar ritems 23s or 28s-fsi diret must be notified Funeral Director	8413 Pioneer	Drive			21144				USA			
or de	11. Marital Status	12. Was Dacede Armed Force	is?	13. Was D if Yes,	ecedent of specify Cul	Hispanic Or ban, Maxicai	igin? (Spe n, Puarto	ecify Yas or No- Rican, atc.)		ce - Americ ck, White,		
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5	30. Name and address of pers	on who completed cause of	of death (Item 23a)	(Type, Print)	1110	010		FIN	MATUNI	1a 1	10	
	31. Date filed (Month, Day, Ye	32 72-	interes Signature	LI	VIVLV	101)		6 > 10	" IL LI ILI	10 10	V	
State Registrar	A DD	n 6 1999	Separature	19.	100	eks						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month April 16, 1999 **Physician** Louiseana Wallace 4:45 P.M. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 15 Arthur King Road Prince Frederick Calvert Months Deys Hours Min. Feb. 7, 1921 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 10M ZEF 78 220-16-8978 Yrs. Director Maryland Usual Residence of Decedent the Manyland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits shov r than "natural", or items 23a or 28a-f short the Medical Examiner must be nothed at 1 ☐ Yes 2 No Calvert Director Maryland Prince Frederick 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? death with 15 Arthur King Road 20678 USA 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☒No tf Yes, Give Yeer or Detes: 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exemples. 1 Never Married 2 Married Specify: Black altimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Domestic Someone else's home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Blake. Chew Mary Revnolds 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Alton Tyler/Son P.O. Box 653 Prince Frederick, MD 20678 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriai 2 ☐ Cremetion 3 ☐ Removel from Stete 4/21/99 Solid Rock Church Cem. Port Republic, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart fellure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Finel Cazeinoma Ovarian diseese or condition resulting in death) Examiner Due to (or es e consequence of) Examiner physician and the buriel-transit Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Couse (Diseese or injury that inhibited events resulting in deeth) Lest Due to (or es e consequence of): Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of): ettending p ed by the e Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec Dleane 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown ğ Completed Vascul 24e. Wes an eutopsy performed? 24b. Were autopsy findings evellable prior to completion of cause of deeth? s certificate has b director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturei 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 - Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical ☐ Solution in the best of my knowledge, deeth occurred at the line, date and piece, and due to the cause(s) and manner stated.

2 ☐ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. 29b. Signeture end title of certifier Monday 29c. License number nums, MD 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Road HOST 303 110

State Registrar

31. Dete filed (Month, Dey, Yéar) APR 2 0 1999

32. Registrer's Signeture

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dis	mediate Ceuse saese or condition sulting in death)	(Finel	a. BRON	CHIAL AS	STHMA r es e consequ	ence of):					
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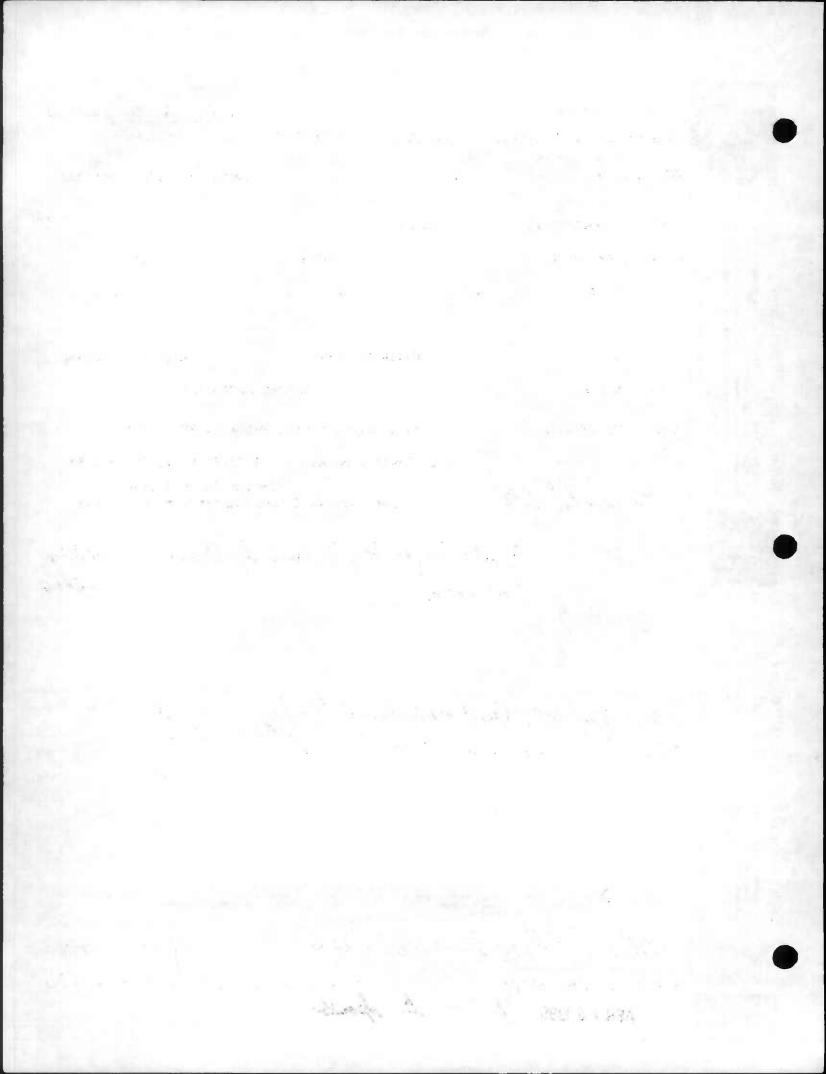
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State of Maryland / Department of Health and Mental Hygiene 00

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State of Maryland / Department of Health and Mental Hygiene Q Q

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'n	Hospital A hours Funeral tely filled		29a. Certifier 1 ☐ Certifying Pl	nysician: To the b	est of my kno	owledge, deeth	h occurred o	et the ti	me dete er	nd place.	and due to the	cause(s) end m	enner es s	tated	
	To the Hospital or A within 24 hours efter To the Funeral Dire completely filled in b	edical		miner: On the bas end menne	is of examine	etion end/or in	vestigation,	in my	opinion, dea	ith occur	red et the time,	dete end plece,	end due to	the cause	(s)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Deeth April 9, **Physician** 7999 Anna M. Willauer 10:26 A.M. /Medical 4b. Cify, Town, or Location of Death 4a Facility Nama (If not institution, giva straet and number) 4c. County of Death Examiner Prince George's Hospital Center Prince George's 8. Date of Birth (Month, Dey, Yeer) If Undar 1 Yaar Birthptaca (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Months Days Hours 1 M 2 XF Yrs. Director 176-32-2168 Nov. 19, 1907 Pennsylvania Usuat Residence of Decedent deeth with the Marylend 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Prince George's Mitchellville 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 10450 Lottsford Apt. 327 Rd. 20721 U.S.A. Funeral 12. Was Decedent Ever In U.S. Amed Forces?

1 (A) Yes 2 (1) No. If Yes, Give 1 (2) 42-58 14. Raca - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Nevar Married 2 Married 1 ☐ Yes 2 A No Specify: Baltimore, Maryland 21215-0020 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglena. College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Peges 1 and 2 should be filed with Depertment of Health and Mental Hyglen Important: if item 27 is marked other that any Injury or other traumatic event, that page. U.S. Navy Military 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surnama) Be Frank R. Willauer Alice Cressman 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Norma J. Robinson/Friend 10450 Lottsford Rd. #214, Mitchellville, MD20721 20b. Placa of Disposition (Neme of cemetery, cremetery or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 ☐ Buriel 2 ☐ Cramation 3 🗓 Removal from State Forks Cemetery 4/19/99 Stockertown, PA. 4 ☐ Donation 5 ☐ Other (Specify) 21, Signatura Plama and Address of Fecility Peorge P. Kalas Funeral Home, P.A. Funeral Service Licen a 6160 Oxon Hill Rd. Oxon Hill, MD 20745 Approximate Interval Between Onset and Deeth 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Hypertension Examiner Due to (or es a consequença of) Examiner Cardiac Disease physician end s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Last Dua to (or es e consequenca of): Parkinson's Disease Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or as a consequenca of): 98 attending for usa es 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown Glaucoma p 24b. Were autopsy findings aveilebla prior to 24e. Wes en eutopsy Completed peen completion of cause of death? paga 2 has 1□ Yes 2\ No 1 □ Ves 2 □ No cartificate or Attending Physician: director, Be 25. Wes case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Dey Year) 27. Mapner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending daath. 1 Yes 2 No neral Director: A filled in by the f 2 Accident investigation 3 Suicida 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) aftar 4 Homicide 24 hours a Hospitai edical 29a. Certifier 1 🖰 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and manner as stated. stely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner stated. (Check only one) To the I 29c. Licensa number 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certifier D52222 April 12, 1999 30. Nama and addrass of person who completed cause of deeth (Item 23e) (Type, Print) Meera Kanhouwa, M.D. 3001 Hospital Dr. Cheverly, MD 20785

DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Dey, Year)

APR 1 3 1999

32/Registrer's Signeture

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middla, Last) **Physician** APRIL 9,1999 JEROME: WILCOX 9:49pm /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner PRINCE GEORGES PRINCE GEROGES HOSPITAL CHEVERLY If Under 24 Hrs 9. Birthplace (Stata or Foreign Country)
D.C. 8. Date of Birth (Month, Day, Year) NOV. 27,1950 5. Social Security Number Sex MM 2□ F 7. Age (In yrs. lest birthday) **Funeral** Months Hours Days 579-66-7224 48 Director Usual Residence of Deceden Pegas 1 end 2 should be filed within 72 hours after death with the Maryland nant of Heelth and Mentel Hygiene.
Int: If item 27 is marked other than "naturef, or items 23s or 28s-f show ary or other treumetic event, or Medical Examinal must be notified as 10d. inside City Limits 10a. State 10c. City. Town or Location 10b. County 1XXes 2□ No Directo Md. Prince Georges Largo 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? 20774 U.S.A. 330 HARRY S. TRUMAN DRIVE Funeral 12. Was Decedent Ever in U,S. Armed Forces? 12 Yes 2 □ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Stetus 1 Never Married Married 1 ☐ Yes 2XX o Specify: Specify: Black Baltimore, Maryland 21215-0020 P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) Cotlege (1-4or 5+) 2years Master Barber 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Surnama) Sallie Lee Black John Henry Wilcox 19e. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Marveline Wilcox/Wife 330 Harry S. Truman Dr., Largo Md. 20774 20b. Place of Disposition (Nama of cematary, cramatory or othar place) 20c. Location - City or Town, State 20a. We had of Disposition

1 Burlal 2 Cremation 3 Removet from State Date permit. Pege Department of Important: If eny injury or once. Harmony Memorial Park 4/15/99 Landover, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road, Landover Md. 20785 23a. Part1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel 3 w/cs LIVER FAILUNE disease or condition resulting in death) Examiner Due to (or as e consequence of) Examiner Accordic Curhosis physician and s the bunal-transit The law requires that the death certificete be axecuted Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last P.O. Box 68760. Physician/Medical Due to (or as a consequence of) signed by the a Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings evaltable prior to completion of ceuse of deeth? been si 24a. Was an autopsy Completed After this cartificete hes funerel director, page 2 R No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medicat examiner? Be 26. Piece of Death (Chack only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes (NO 1 Chpatient 2 ER/Outpetient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 1/Devaturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Straat and Number or Rurel Route Number, City or Town, Stata) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and menner es steted.

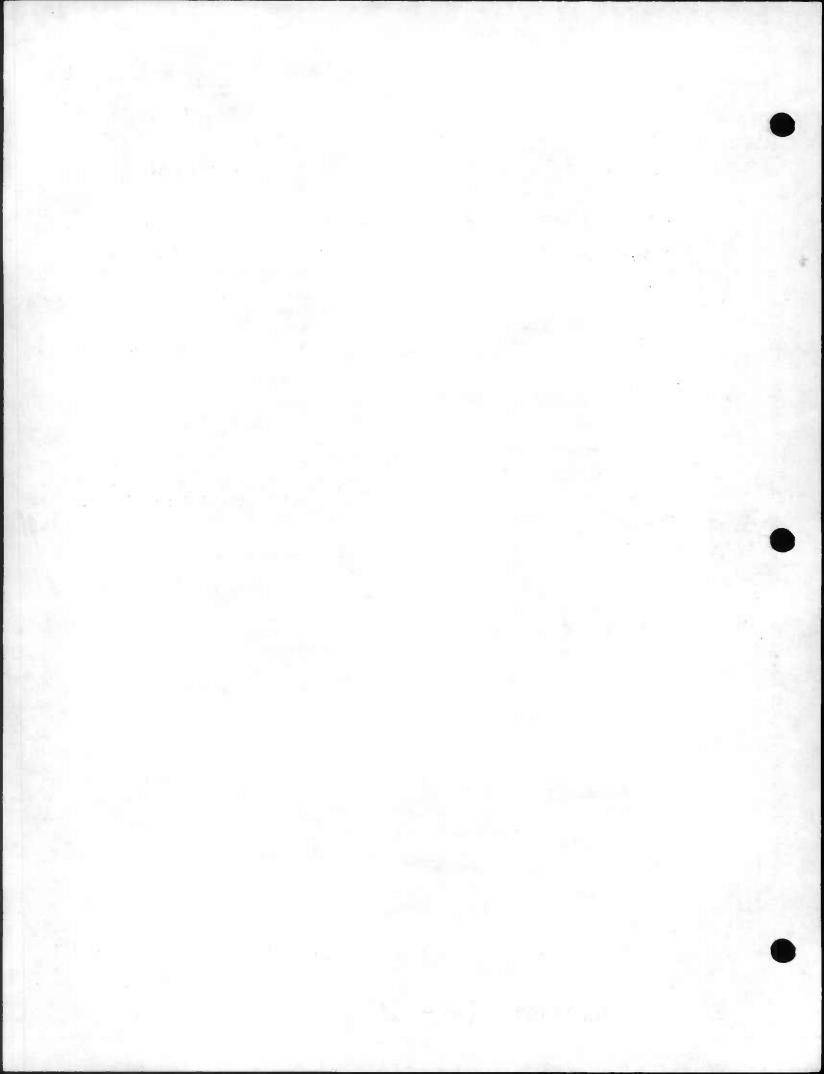
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier 9, 1999 un! 10 who completed cause of death (Item 23a) (Type, Print) ors Prince george's Hospild Canter, 30 opensoul a Chavel, 000 32 Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 150 pm Hyong Dong Yeo April 2, 1999 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Howard County General Hospital Columbia If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Dey, Year) Oct 26, 1934 6. Sex 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 212-15-4466 Yrs. 64 Director South Korea Usuel Residence of Decedent 10a Stele 10b. County 10c. City, Town or Location 10d. Inside City Limits rithan "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Howard Ellicott City 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4781 Leyden Way 21042 South Korea 14. Reca - American Indien, Black, White, etc. 11 Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 72 hours after 1 Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: 20 3 ☐ Widowed 4 ☐ Divorced Oriental Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "na eny Injury or other treumstic avacations." Elementery/Secondery (0-12) College (1-4or 5+) Owner Grocery Store 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Sang Eun Yeo Suk Yi Kim 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4781 Leyden Way Ellicott City, MD 21042 Hwan Jong Yeo/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slete 1 Buriel 2 Cremetion 3 Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Good Shepherd Cemetery 4-6-99 Ellicott City, MD 21. Signature of Funeral Service Licanses 22. Name end Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. a Colle There 4112 Old Columbia Pike Ellicott City, MD 21043 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feiture. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Heute Myocardial Ischemia disease or condition resulting in deeth) Examiner Cardio vascular Disease Examiner The law requires that the death certificate be executed and Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thef initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 980 Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yss 2 No 3 Probably 4 Whiknown Left-hemisphere stroke (1993) Records, þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. fnjury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending 1 Naturel n 24 hours after death.
The Funeral Director: After the funeral by the funeral by the funeral by the funeral in by the f 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide Hospital 1 Confiring Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) within 2 94 29b Signature and fittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) at Ca 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) ione Way Elliat City MD 21042 PATRYCE A-TOYE, MB 4565 temlock 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture APR 0 5 1999 Registrar



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** ZACHARY BERNICE 7:36 PM /Medical 4a. Facility Name (If not institution, give straat and number) 4b. City, Town, or Location of Death 4c. County of PRINCE Examiner **TANHAM** DOCTORS HOSPITAL If Undar 1 Yaar Months Days Hours Min. Ap Hornh, Ban Year 14 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Country) LOUISIANA **Funeral** 1□M 2 F 116-10-3938 Director Usual Rasidence of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Md. P.G. Director 1X Yes 2 No Upper Malboro 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? U.S.A. 20774 1003 Folcroft Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarlo Rican, etc.) 11. Marital Status Was Decedant Evar In U.S. Armed Forces? 14. Race - American Indian, Black, Whita, atc. 1 Nevar Married 2 Married 1 □ Yas 2 📉 No If Yas, Giva 1 ☐ Yas 2 No Specify: þ 3 Widowed 4 Divorced Yaar or Datas: Black Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. KInd of Businass/Industry College (1-4or 5+) 2years Elementary/Secondary (0-12) Medical Assistant Private 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumama) Be Peter Tomas 2 Adele Davis 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Earl B. Zachary/Husband 1003 Folcroft Lane, Upper Malboro, Md. 20774 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1

☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4/12/99 Landover, Md. Harmony Memorial Pk 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover Md. 20785 23a. Part1. Entar tha disease, or comb ath. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, Approximate Intarval Between Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Physician/Medical Examiner Sequantially list conditions, if eny, laading to immediata cause. Entar Underlying Causa (Disease or Injury thet initiated evants resulting in daath) Lest ageunce of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uaa contributa to the causa of death? 1 ☐ Yas 20 No 3 Probably 4 ☐ Unknown þ 24b. Wara autopsy findings availabla prior to complation of cause of death? Completed 24a. Was an autopsy performed? 1 Tas 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical exeminar? Be 26. Plece of Death (Check only ona) Hospitel: 1 ☐ Inpatiant 2 SER/Outpatient 3 ☐ DOA 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 27. Manner of Death 28b. Tima of Injury 28e. Deta of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No invastigation 3 ☐ Suicida 6 Could not be datamined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide Certifying Phyelcien: To the best of my knowledga, death occurred at the time, dete end place, and due to the cause(s) end mannar as steted.

2 Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. Medical 29a, Cartifier (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Date signad (Month, Day, Year) 30. Nama and address of person who completed cause of deeth (Itam 23a) (Type, Print) onoson MD 37. Ragistrar's Signatura State

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I Director: After the function of the function o

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The law requires that the death certificete be executed

Box 68760

P.O.

Records,

Division of Vital

Hospital or Attending Physician:

Pages 1 and 2 should be nent of Health and Mental

Separtment of

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State Registrar

31. Dete filed (Month, Day, Year)

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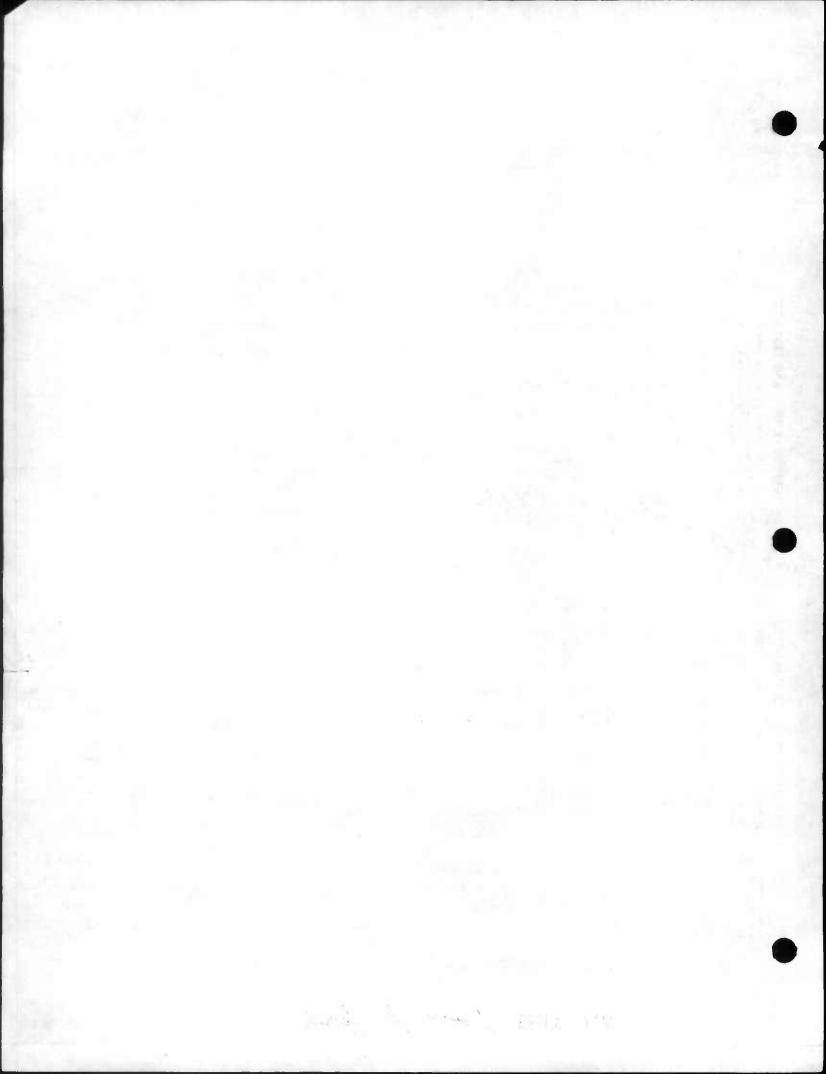
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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/32. Registrar's Signetura



	Iten	1#19	b perFHG771 5/3/99 EW			Ce	rtifica	te of	Death		Reg. No.		
	Physic	ion	1. Decedent's Neme (First, Middle, La	st)						2. Dete of Do	eeth Dev	Yeer	3. Time of Death
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	land		Usuei Residenca of Decedent 10a. Stete 10b. County		10c. Ci	ty, Town or Le	ocation					1	0d. Inside City Limits
	ter death with the Marylan items 23s or 28s-f show inst must be notified at	Director	Maryland Worcest	er	Poo	comoke							1 ☐ Yes 2 ☐XNo
	vith to		10e. Street end Number					p Code			10g. Citizen of		itry?
	a 23	srai	4217 BETHEDEN COU					851			USA		
020	n 72 hours efter death with the Maryland "natural", or Hema 23a or 28a-f show edical Examinet must be notified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Fo 1 Yes if Yes, Giv Year or D	2 ⊠ No ⁄e		was Dece If Yes, spo 1 Pes	ecify Cub	Hispenic Origin? (Spen, Mexican, Pue	Specify Yes or No to Rican, etc.)	Ble	ce - Americ ck, White, fy: rican	
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gre	ducation		16e. Dece	dent's Usi	uel Occu	petion during most of wa	nrkina	16b. Kind of E		
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Maryland	should be nd Mentel marked c matic ev	TOE	JOHN HENRY AYRES						HENRIET	TA TAYLO)R		
al	2 should end Men is marks aumatic		19a. Informent's Name/Relationship (Type, Print)		19b. Maili	ng Addres	s (Stree	t end Number or F	ural Route Numb	per, City or Town	, Stete, Zip	Code)
	2425		John Townsend/nep	hew		same	as a	bove	4217 Be	theden Cou	irt Pocomo	ke Cit	y,MD 21851
=			20e. Method of Disposition 1 □XBurlel 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specifi		Stete	Plece of Disponentery, cres	metory or	other ple	ece) Irch Cem.	Date 4/17/99	20c. Location		
Balt	permit. Page Depertment of Important: If sny Injury or once.		21. Signature of Funeral Service Licenta	esto.	lley	25	2. Name e JOLL	nd Addr	ess of Facility12. IEMORIAL	13 JERSE CHAPEL	Y ROAD	- SAL	ISBURY, MD
	Physician		23a. Part1. Enter the diseese, or com shock, or heert feilure. List only	one cause on e	ach line.	h. Do not en	ter the mo	de of dy	ing, such es cardia	c or respiretory e	errest,	1	Approximete Intervel Between Onset end Deeth
νl	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting In death)	e. 41		/ ERO			Diovascu	tow d	150 me	>	IOYR
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X OX	d for u	Iclar	Pert II. Other significant conditions or	entributing to de	eth but not roo	ultina la tha u	ndodvina	201102 0	iven In Part I	22h Did	tohanno usa a	amérikusa és	the cause of death?
7. O	that the led by th detache	y Physician/Medical						_	WGITHIT GIVI.		Yes 2□ No		pably 4 Unknown
	requir should	Completed by	PER i phemal								s en eutopsy ormed?	ev	ere eutopsy findings eliable prior to impletion of cause deeth?
H	The lew ate has t page 2 s	mo								10	Yes 20No		Yes 2 No
	certificate rector, pag	Be C	25. Wes case referred to medical						26. Plece of De	ath (Check only			
>	5 00	To	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗆 I	npatient 2	ER/Outpetier	nt 3 D	OA Ot	har a	Home 5 ☐ Res		her (Specif	v)
ם חס	ath. r: After thi e funeral	ation:	27. Manner of Deeth Naturel 5 Pending Accident investigation		of Injury h, Dey Yeer)	28b. Time o Injury	f M	28c. Inju Wo	iry et ork?] Yes 2 □ No	28d. Describe	how Injury occu	rred	

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending within 24 hours effer death.

To the Funeral Director: After completely filled in by the fun

Medical Certificati 2 Accident 3 Suicide 4 Homicide

29a. Certifier (Check only one)

6 Could not be determined

28e. Pleca of injury - At home, farm, street, factory, offica building, etc. (Specify)

Lactifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

| Continue of the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner stated.

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29b. Signeture end title of cartifier I wans lue

MD

29c. License number

29d. Date signed (Month, Dey, Year)

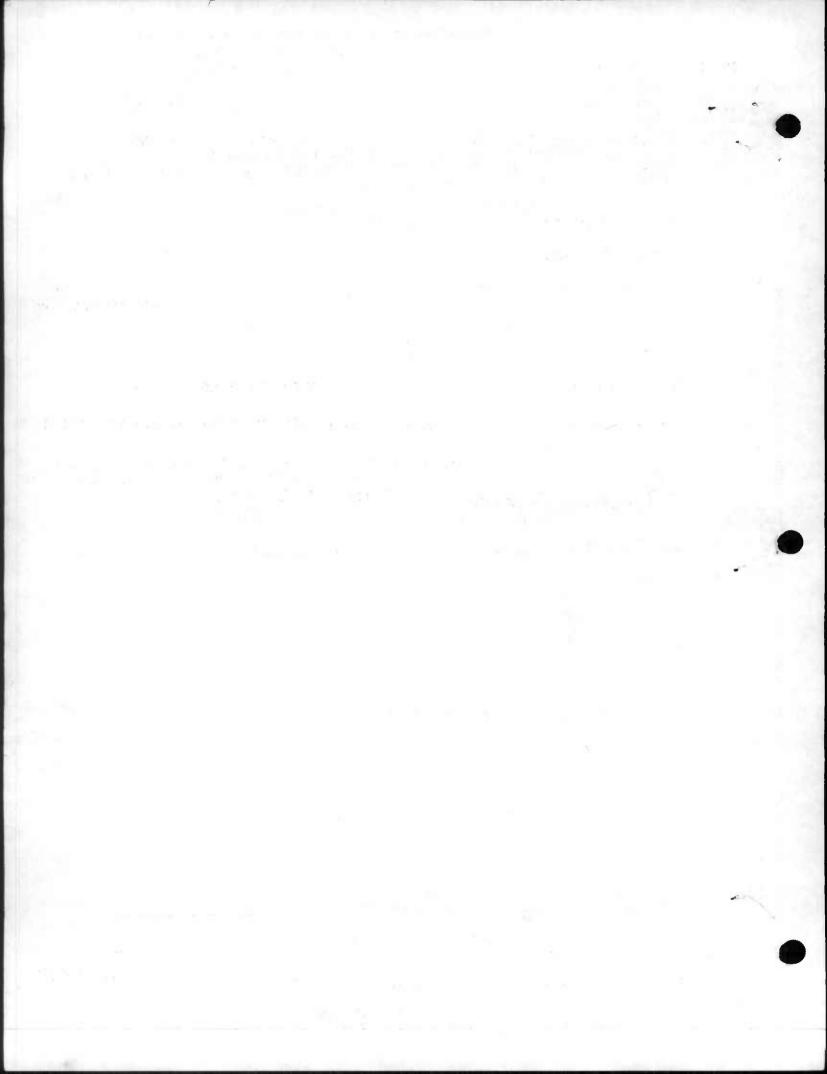
30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print)

106 mil FORD St Sillin 504B suisyey no 2/504 MAHESH MOO udva MD 31. Dete filed (Month, Day, Year) .

State Registrar

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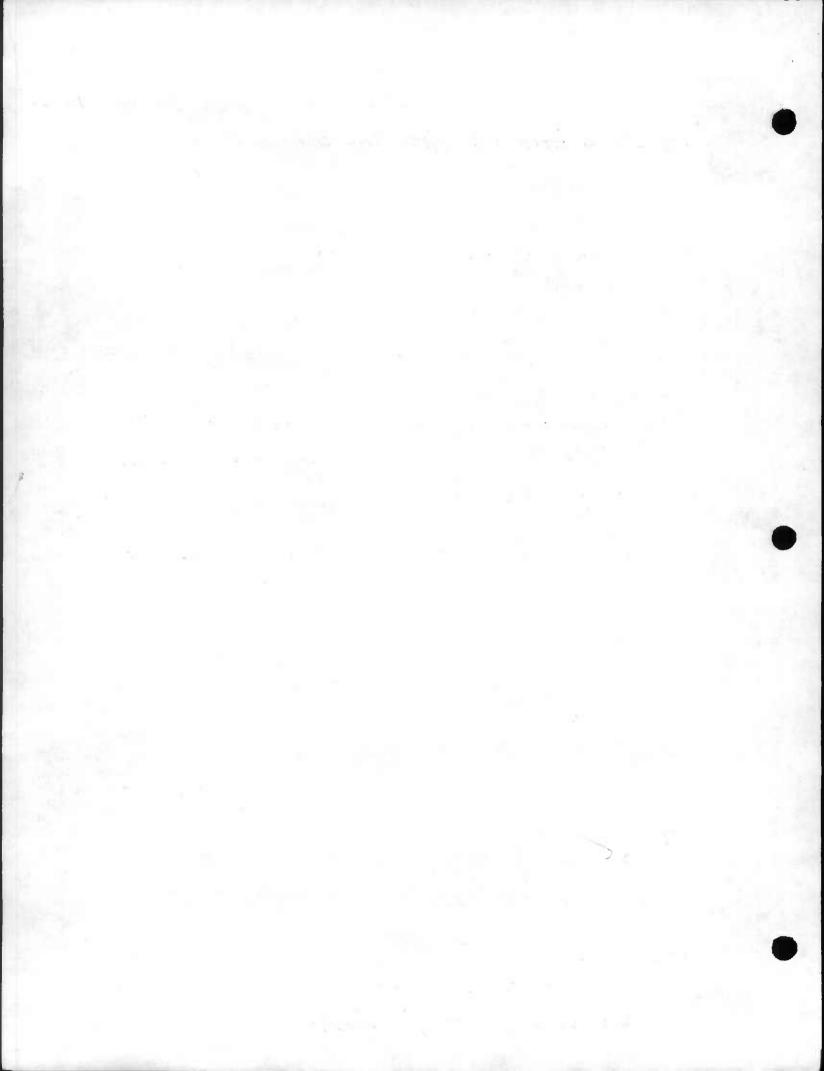




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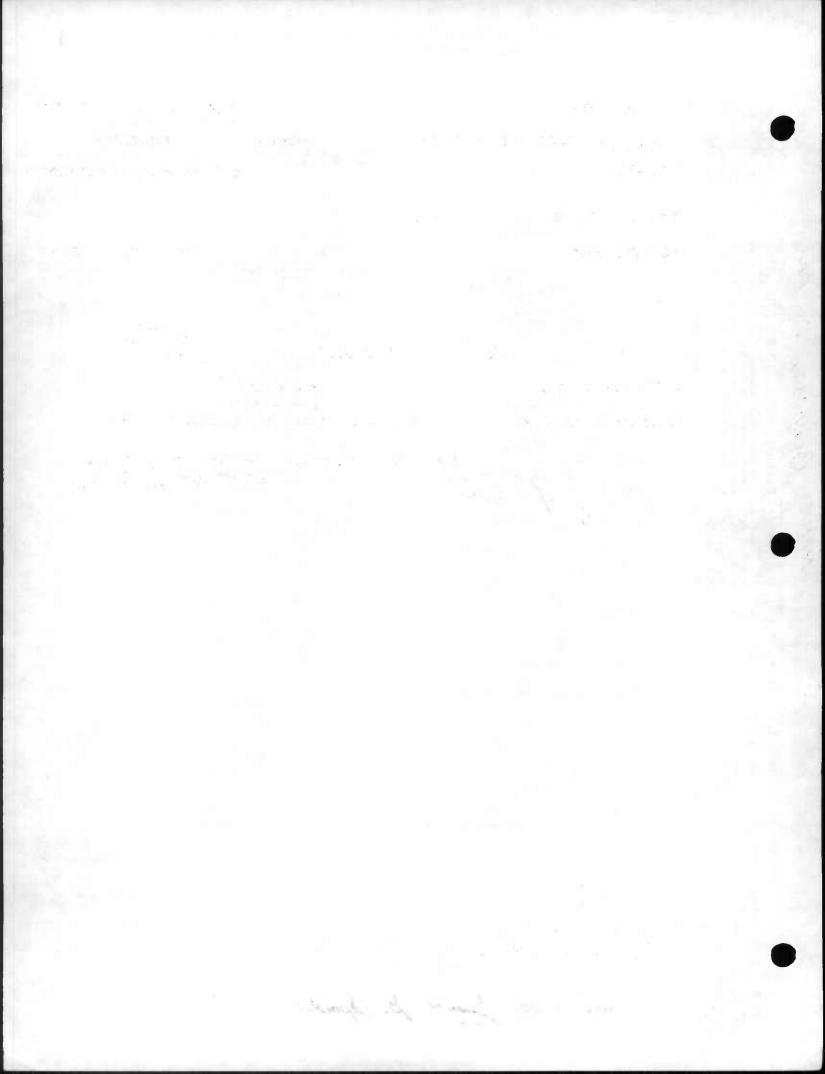
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State of Maryland / Department of Health and Mental Hygiene

					Ce	rtificate	of i	Death			Reg. No.		
	1. Decedent's Nem	ne (First, Middle, La	ist)							2. Dete of De	eeth	M	3. Time of Deeth
ysician	Ralph Stul	1 Bennett								Month APRIL	Dey 2.8	Yeer 1999	12:47PM
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1	5. Sociel Security N			Age (In yrs. le		If Under		If Under	24 Hrs.	8. Date of Bi	rth	9. Birthi	plece (Stete or Foreign
	501-01-3979 Usuel Residence o	7	1[XM 2□ F	90	Yrs.	Months	Deys	Hours	Min.	August 2	20, 1908	Cou	rick, Maryland
	10a. Stete	10b. County		10c. City	Town or Lo	ocation						1	10d. Inside City Limits
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ruleia Dieco	10e. Street and Nu		-	1		10f. Zip	Code				10g. Citizen	of What Cou	ntry?
	800 Souther					2	21286				United S		of America
	11. Merital Status		12. Wes Decede Armed Force		5. 13.	Wes Decede	ent of H	lispenic Ori en, Mexicer	gin? (Sp	ecify Yes or No Rican, etc.)	0- 14. [Race - Ameri Bleck, White,	
	1 ☐ Never Marr 3 ☑ Widowed	ried 2 Married 4 Divorced	1 Yes 2[If Yes, Give Yeer or Dete			1□Yes 2		Specify:				ocity: Whi	ite
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	William Co	mfort Benne	ett					Nettie	Stu	11			
		lame/Reletionship				-				rei Route Numb			p Code)
l	Mr. Willia	m R. Bennet	t(Son)		458 Ne	ewtown	Turnp	oike	Redd	ing, Conr	necticut	06896	
	20a. Method of Dis		70	00	metery, cre	osition (Nem	e of her place	ce)		Dete	20c. Locati	on - City or T	own, Stete
		5 ☐ Other (Speci	Removel from Sta	te		vice Co		•	5	/01/1999	Towson	. Marvla	end
ŀ	21. Signature of Fu		-	L. Gair	2	2. Name end	Addre	ss of Fecilit	v Ruc	k Towson	Funeral	Home,	Inc.
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	shock, or hea	art failure List only	plications that cause on each	sed the death h line.	. Do not en	ter the mode	of dylr	ng, such es	cerdiec	or respiretory e	errest,		Approximete Intervel Between Onset and Deeth
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	Cause (Disease or thet initieted event resulting in deeth)	S	c	Due to (or	as e consec	quence of):							
		L	d										
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	Pert II. Other signi	ficent conditions	contributing to death	n but not resu	iting in the u	inderlying ce	use grv	en in Pert i					to the causa of death?
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										24e Wei	s en eutopsy	24b. W	Vere eutopsy findings
l										perf	ormed?	91	veilable prior to ompletion of ceuse
l													f deeth?
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Ì	27. Mannes of Deat 1 Id Natural 2 Accident	th 5 Pending investigetio	28e. Dete of I	njury Dey Year)	28b. Time o Injury	of 28	Bc. fnjur Wor	yet k? Yes 2□	No	28d. Describe	how Injury or	ccurred	
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Plece of	Injury - At hor etc. (Specify,	me, ferm, st	reet, factory,	office				(Street end Nown, Stete)	umber or Rui	rel Route Number,
ŀ													
	29a. Certifier (Check only one)		nyafcian: To the be miner: On the basis end menner	of examineti									
	29b. Signature and	title of certifier	10			29c.	Licens	e number			29d. Dete si	gned (Month	, Day, Year)
	1/5	. (/	Sal	1	-		70	04	30	189		4/2	1/99
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	30. Neme and edde	ress of person who	completed cause of	of death (Item	23e) (Type,	, Print)							
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	31. Dete filed (Mon	ntn, Dey, Year)		strer's Signet	ure /	1	m	15					
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Division of Vital Records, P.O. Box 68760,

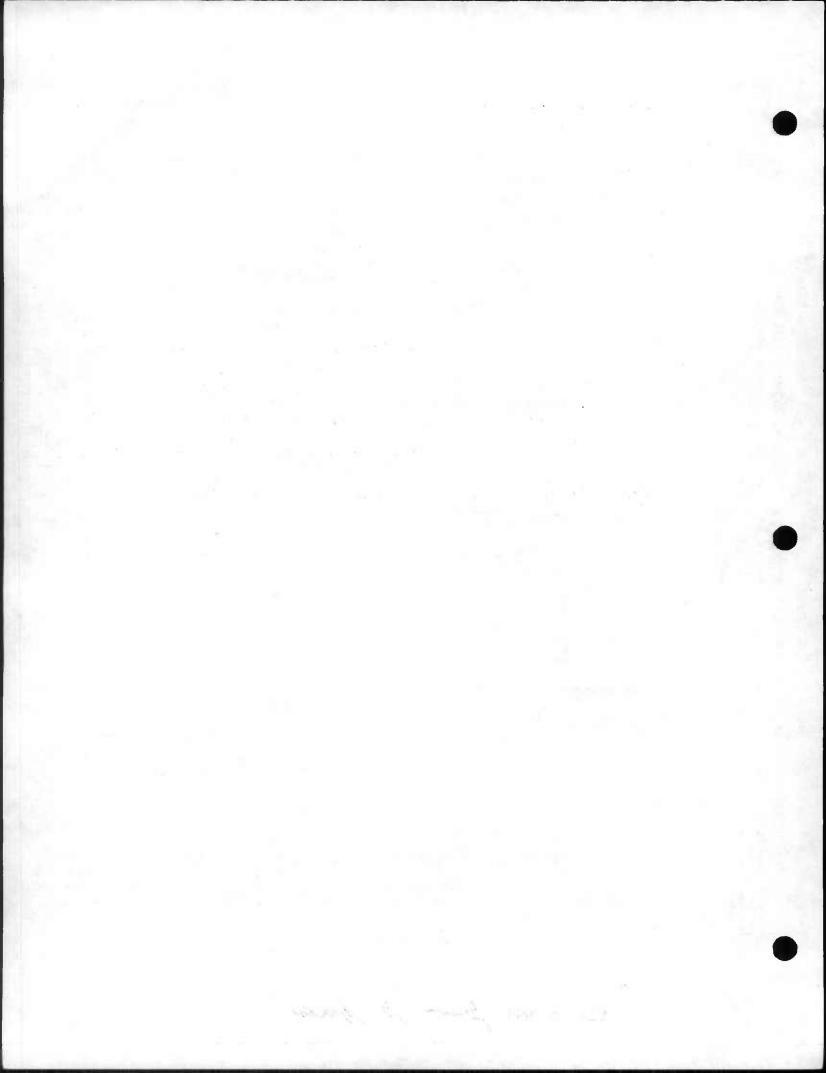
Bennett, Ralph



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 | 4 2 | 2

			Certificate of	Death	Reg.	No.	
	1. Decedent's Name (First, Middle, Last	0		2	. Dete of Deeth		3. Time of Death
Physician Medical	Frank Joseph	Battaglia		1	Month 1a v	3, 1999	2:04 am
Examiner	4a Facility Name (If not institution, give			4b. City, Town, or Loca		4c. County of Death	
	Blakehurst He		hirthday) If Under 1 Yee	Towson		Baltimor	
Funeral Director	5. Social Security Number 6. Se 2 1 4 - 0 3 - 6 5 0 9 Usual Residence of Decedent	7. Age (In yrs. last 85	Yrs. Months Days	Hours Min.	Month, Dey, Ye - 19-19	er) 9. Birthp Coun 13 Mary	elece (Stete or Foreign stry) 1 a n d
Pu M	10a. State 10b. County	10c. City, T	own or Location			1	0d. Inside City Limits
28e-f sh entired	MD Baltimo	re	400 Tin Onda		40-	011	1 ☐ Yes 2 ☑ No
after death with the Marylar or items 23s or 28s-f show mitter man be notified at / Funeral Director	1055 W. Joppa		10f. Zip Code 2120		US		
5 5 5 6	3 ₩ Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? Nav 1 12 Yes 2 No If Yes, Give 2/42 to Year or Dates: 9/45		Hispanic Origin? (Speci ban, Mexican, Puerto Ri Specify:	ly Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
72 hours netural',	15. Decedent's Edu (Specify only highest grad	ecation 1	6a. Decedent's Usuel Occu	pation	16b	. Kind of Business/inc	dustry
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Mentel Mentel Mentel Mentel To B				Cather	ine DeM	larco	
E SEE	19a. Informant's Neme/Relationship (T)	pe, Print) daughter	19b. Mailing Address (Stree	t end Number or Rural I	Route Number, Ci	ty or Town, Stete, Zip	Code)
CENL	Karen S. Schust		6612 Towering			2.1	1044
mit. Pages 1 and; partment of Health portant: if Nem 27; y Injury or other it	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removel from State	e of Disposition (Neme of etery, cremetory or other pla tlawn Memorial	ece)	Dete 20c	Location - City or To	
pemit. Pag Department Important: I eny Injury o	21. Signature of Funeral Service License			nkling St.,			
death certificate be assected e attending physicien and for use as the burlal-transit	Cause (Disease or injury that initiated events resulting in death) Last	b	e consequence of):		unh	nown	
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Affar this funeral i	27. Manner of Death 1 D Natural 5 Pending		b. Time of 28c. Injury	ury et 28 ork?	d. Describe how i		,,
or Attendent dast Niector: In by the	2 Accident 3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)		Yes 2 No 28	f. Location (Stree City or Town, St	t end Number or Rura tate)	al Route Number,
To the Hospital within 24 hours To the Funerel completely filled	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my knowled ner: On the basis of examinetion and manner steted.	dge, death occurred et the t end/or investigetion, in my	ime, dete end plece, en opinion, death occurred	d due to the cause et the time, date	e(s) end manner es s end place, and due to	teted. the cause(s)
To the complete complete Mex	29b. Signature and title of certifier	- Mul	MA 29c. Licen	se number	29d.	Date signed (Month,	Dey, Year) 1999
	- / 1 11	ompleted cause of death (Item 28	(a) (Type, Print)	e Ms		2/1210	
State	31. Date filed (Month, Day, Year).	32. Registrar's Signature	A la	2. 1/2/		į.	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Marie Catherine Braun 1999 May 1, 6:45am 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Ridgeway Manor Nursing HOme Catonsville Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Say 7. Aga (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 1□M 2ØF Months Days 218-36-7847 90 Yrs July | 30, 1908 Maryland Usual Rasidance of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits Baltimore Catonsville 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5743 Edmondson Avenue 21228 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ∑ No If Yas, Giva Yaar or Datas: 14. Race - American Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Nevar Married 2 ☐ Married 1 Yas 2 No Specify: White 3XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Maryland State Elamantary/Secondary (0-12) Collega (1-4or 5+) Secretary Government 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Hugh Edward Craven Mary McNerney 19a. tnformant's Name/Ralationship (Type, Print)
Elizabeth A. Phipps (Niece) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 10183 Karenlee Court, Ellicott City, MD 20b. Place of Disposition (Nama of cematery, crematory or other place) Data 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ⊠ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 5/4/99 New Cathedral Baltimore, Maryland 4 □ Donation 5 □ Othar (Specify) 21. Signature of Funaral Sarvice Licensee 22. Nama and Address of Facility Witzke FUneral Homes, Inc. 1630 Edmondson Avenue, Catonsville, Maryland 2122 Lemmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death Immediata Causa (Final disaase or condition rasulting in deeth) Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case rafarred to medical axaminar? 26. Place of Deeth (Check only one) Hospital: 1 Yas ZE No Other: Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death

1 Natural
2 Accidant 28a. Data of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation 1 Yes 2 No 6 Could not be datarmined Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) to Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated.

/Medical Examiner The law requires that the death cartificate be executed Box 68760, P.O. of Vital Records, Physician: Division or Attending

Physician/Medical Examiner Be Completed by Certification: To this Aftar within 24 hours after death.

To the Funeral Director: A completely filled in by the fu edical the

Physician

/Medical

Examiner

10a Stata

MD

11. Marital Status

Funeral

Director

28a-f show

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Herma :

e filed within 72 hours aftar of Hygiana.

permit. Pagas 1 and 2 should be file.
Department of Health and Mantai Hyg.
Important: If Item 27 te marked other any Injury or other treument.

Physician

Baltimore, Maryland 21215-0020

Examiner must be notified at

Director

Funeral

by

Completed

State Registrar

3 Suicide

29a, Cartifian (Check only one)

4 ☐ Homicide

29b. Signatura and titla of certification

maiden choice 32, Registrar's Signatura

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

29c. License number

29d. Data signed (Month, Day, Year)

5-02. MY).

Johnson

PERF VAM

Present Secret

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day APRIL LOLA BERGTEIN 9:10 PM 1999 29 4b. City. Town, or Location of Death 4c, County of Death 4a Facility Name (If not institution, give street end number) HOSPITAL, LOCH RAVEN BLOOD. MOTISAMAZ BALTIMORE MD 21289 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 1 ☐ M 2 🕅 F 212-09-0896 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits HZ Yes 2 □ No Baltimore City Maryland N/A 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zio Code 21239 USA 6915 Donachie Road 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Residence 12 th 17. Father's Name (First, Middle, Last) Homemaker 18. Mother's Name (First, Middle, Maiden Sumeme) Mary Ellen (Nellie) Driscoll Isidor Charles Bernstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mr. Dennis C. Bernstein (Nephew) 13510 Golden Corn Dr. Highland, MD 20777 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 5/4/99 Baltimore, Maryland Moreland Mem. Pk Cem. 21. Signature of Funerel Service Johnson 22. Name and Address of Facility Martin D. Mitchell-Wiedefeld Home 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS 4 DAYS Due to (or as a consequence of) 4 DAYS PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequenca of) 2 DAYS CLOSTRIDIUM COUTIS DIFFICILE Due to (or as a consequence of) resulting in death) Lest Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Plece of Death (Check only one) Hospital: 1.⊠inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) 27 Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner es steted. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the ceuse(s) end manner stated. (Check only one)

29c. License number

GOOD SPARKITAN HOSPITAL, BALTIMORE MD 21229

P-125 56

29d. Date signed (Month, Dey, Year) MRIL 29, 1999

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Funeral Director: After teely filled in by the funeral or Attending within 24 hor To the Fune completely fi

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

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Physician

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Physician/Medical Examiner

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31. Date filed (Month, Dey, Yeer)

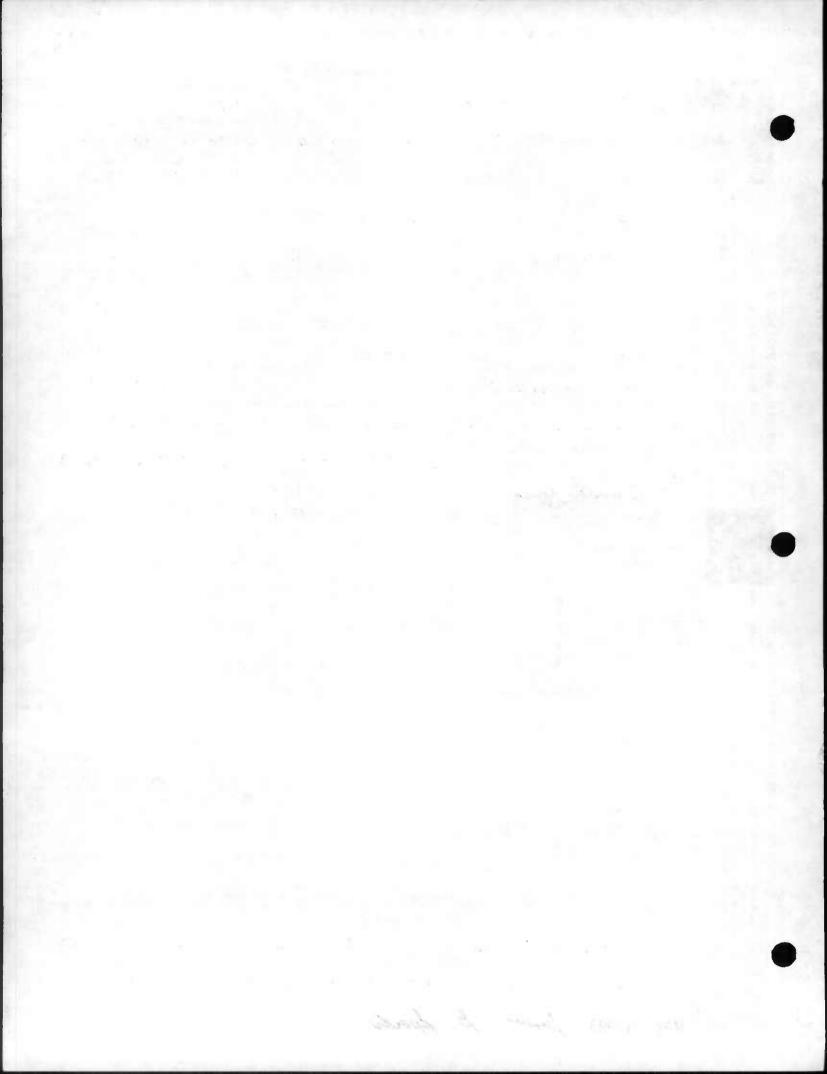
29b. Signature end title of certifier

AJAY CHAWLA, MD

AJAY CHAWLA, MD

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrar's Signature B. Sparks



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Dev **Physician** 1:34pm BANKS 4b. City, Town, or Location of Deeth 26 JAMES /Medical 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. | 8.1 Hos Pital Inai 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country)
 1 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** Deys 1 M 2□ F 229-28-0409 Yrs. -31-19 **Director** Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Baltimore NA Directo Md 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 7 is marked other than "natural", or items 23s or traumatic event, the Magical Examiner must be 5.A Grantley Avenue 2/2/5 permit. Peges 1 and 2 should be filed within 72 hours efter death v Department of Heelth and Mental Hygiene. Important: If itsm 27 is marked other than "naturel", or items 23a any injury or other traumatic event, the Medical Examiner mass once. 2809 Funerai 12. Wes Decedent Ever In U,S. Armed Forces?

1 X Yes 2 No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Status 1 Never Married 2 Married Black 1□Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life_DO NOT use retired) 16b. Kind of Business/Industry UNK 15. Decedent's Education (Specify only highest grade completed) wPholstery Elementery/Secondery (0-12) College (1-4or 5+) NA 12th grade 17. Fether's Neme (First, Middle, Lest) UNA 18. Mother's Neme (First, Middle, Maiden Sumame) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2/2/5 19a. Informent's Name/Reletionship (Type, Print) 809 Wife Baltimore Herenue ord 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from Stete Randalls town, red Memorial 4 ☐ Donation 5 ☐ Other (Specify) Park 14-30-99 21. Signeture of Funeral Servica Licansee 22, Name end Address of Fecility 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feliure. List only one cause on each line. Daltimore. Avenue Approximete Interval Between Onset end Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Sepsis Examiner Due to (or es a consequence of): Examiner ettending physician and for use as the buriel-trensit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown Respiratory Pailure þ 24b. Were eutopsy findings eveilable prior to 24a. Wes en eutopsy Completed completion of ceuse of deeth? certificate has b 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA After this funeral 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Naturel 2 ☐ Accident n 24 hours efter death. e Funeral Director: Atholetely filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier

State

30. Name end eddres of person who completed ceuse of deeth (Item 23e) (Type, Print)

Bolvadere

32. Registrar's Signature

2401 W

Schick

31. Defe filed (Month, Day, Year)

DHMH 16 Rev 6/95

with the Maryland

altimore, Maryland 21215-0020

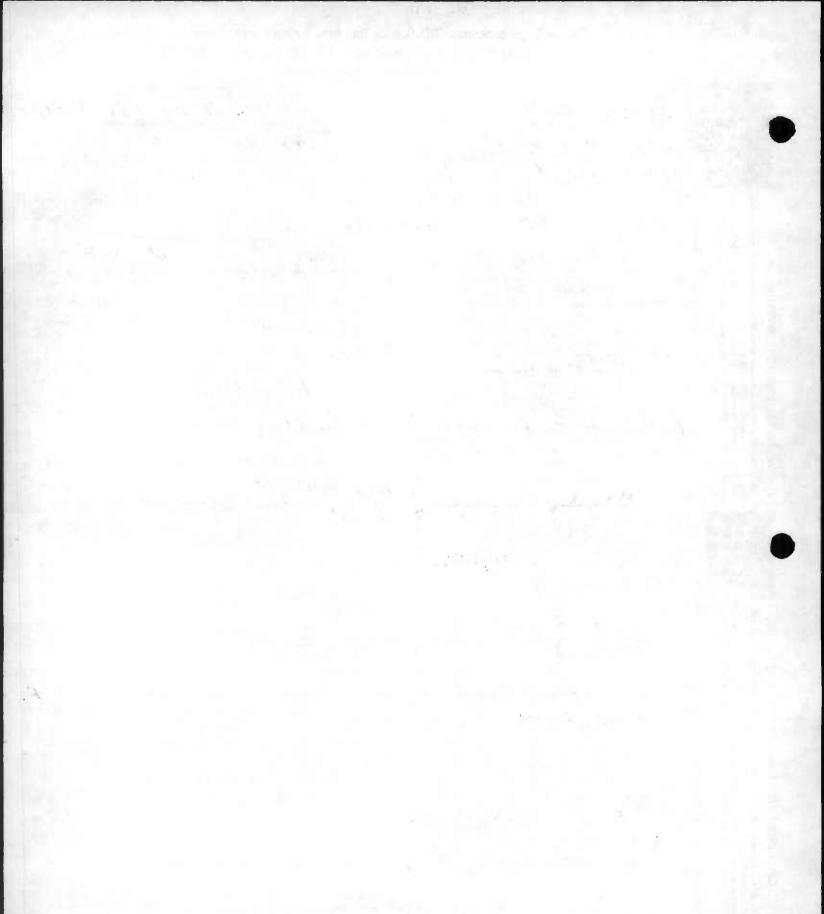
The law requires that the death certificete be executed

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Registrar

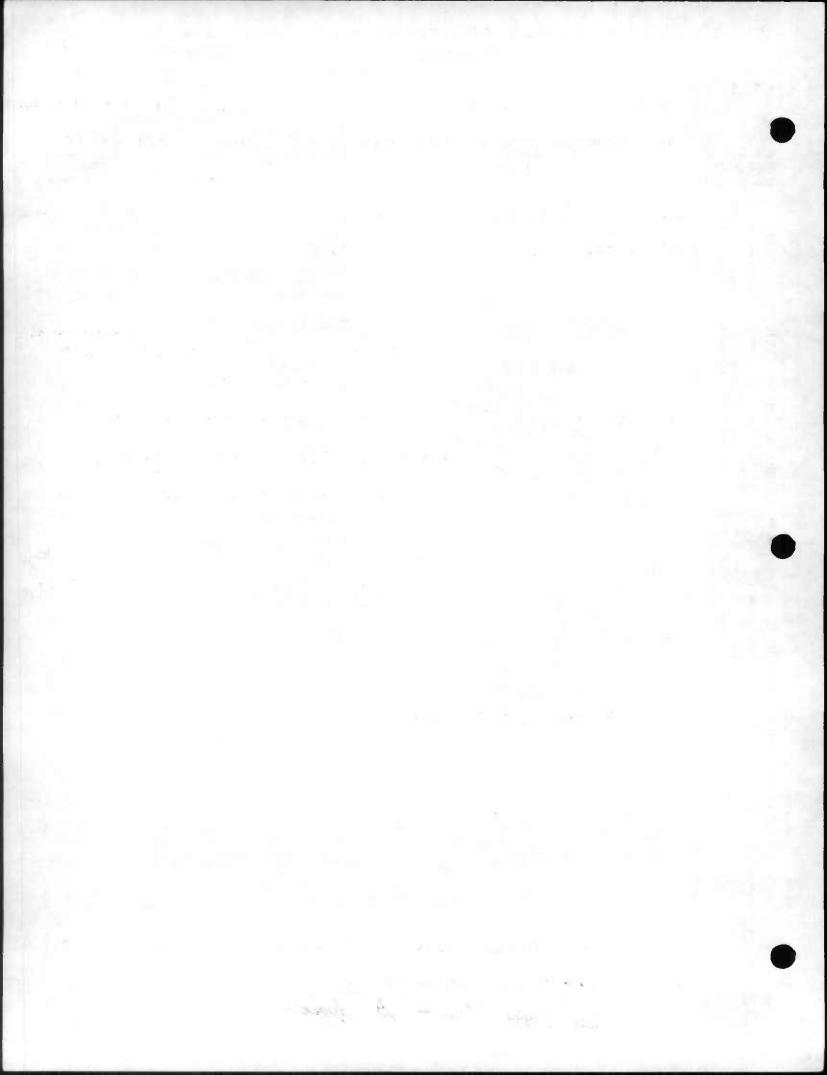
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Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 11:16 AM RRUDKY FLLA 3 27 1999 /Medical 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RALTIMORE GOOD SAMBRITON HOSPITAL BOIHMERE MO 21239 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Months, Dey, Yeer) 5. Sociel Security Number 219–12–7511 6. Sax Birthplece (State or Foraign
Country) **Funeral** Months Deys Hours 1□ M 200 89 Yrs. Director Oct. 3, 1909 Usuel Residence of Decedent the Maryland 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinatins to notified at Md. Anne Arundel Glen Burnie 1 ☐ Yas 3 € No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 6901 Aviation BLVD. 21061 USA Funerai 72 hours efter death 12. Was Decedant Evar in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No If Yes, specify Cuban, Maxican, Puarto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11 Maritel Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 and 2 should be filed within 7 Department of Health and Mentai Hygiene. Important: If Item 27 Is marked other than any injury or other transmets. Dept. of Health & College (1-4or 5+) Elementary/Secondery (0-12) Clerk Welfare / Soc. Sec. 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Frank Dyer Enolia M. Clark 19a. Informent's Name/Reletionship (Type, Print) niece 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 406 Wellham Avenue Glen Burnie, Md. 21061 Enolia Goodwin 20b. Place of Disposition (Neme of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition ₩ Burial 2 Cremetion 3 Removel from State Arbutus Memorial Park May 4 Baltimore, Md. 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 21. Signatura of Funaral Service Licensas 2501 Gwynns Falls PKWY Baltimore, Md. 21216 treel ę multer 23a. Pert1. Enter the disease, or complications that causad the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Intervel Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) SEPJIS Examiner Due to (or es e consequence of): Examiner RUEU MUNIA ician end buriel-trensit law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events rasulting in death) Last Dua to (or as a consequence of): physician es the buriel Box 68760. Physician/Medicai Dua to (or as a consequenca of): 88 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. ed by the e 23b. Did tobacco use contribute to the cause of death? P.0. signed by the 1 | Yes 2 | No 3 | Probably 45 Unknown TRACT INFECTION Division of Vital Records, þ 24b. Were eutopsy findings available prior to completion of causa of deeth? 24a. Was en eutopsy performed? Completed been s certificate has The 2 00 No 1 ☐ Yes 2 ☐ No or Attending Physicien: effer deeth. Director: After this certifice funeral director, 25. Wes cese referred to medicel examiner? Be 26. Plece of Deeth (Check only one) Hospital: 1 Manpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Certification: To 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, streat, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 4 I Homicide filled in 24 hours e Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature end title of certifier 29c. Licansa numbar 29d. Date signed (Month, Dey, Year) AJAY CHAWLA - 125 56 MD 30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) AJAY CHAWLA, GOOD SAMARITAN HOSPITAL, BALTIMORE 31. Dete filed (Month, Day, Year) 32. Registra 's Signature Registrar

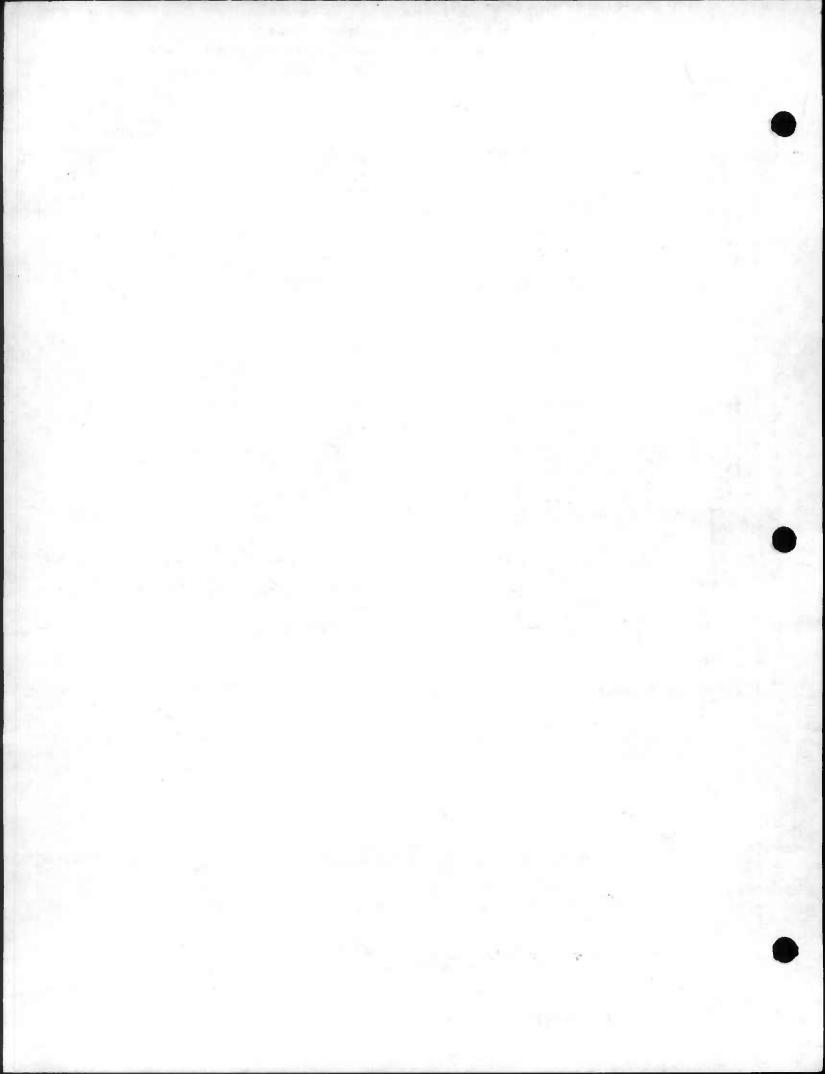


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State of Maryland / Department of Health and Mental Hygiene

	1	. Decedent's Nama (First, Middle, La	et)	Cer	tificate of	Death	2. Data of Deat	eg. No.		3. Tima of Death
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/Medical		a Fecility Nama (If not Institution, giv		, R1	llups	4b. City, Town, or Lo	cation of Death	28 19	999	10:53 a.m
Examiner	r		oital			Baltimore	oution of boutin	NA NA	Of Death	
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D .	-	Jsual Rasidance of Decedant Oa. Stata 10b. County	10c Ci	ty, Town or Loc	cation				1	0d. Inside City Limits
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o20 urs after il; or its		1. Merital Status 1 □ Nevar Married X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forcas? 1 ☐ Yes 2XONo If Yas, Giva Yaer or Datas:		Vas Decedant of I I Yas, specify Cub I ☐ Yas ②☐XNo	dispanic Origin? (Spean, Mexican, Puerto Specify:	ocify Yas or No- Rican, etc.)	Biad	e - Americ k, Whita, Bla	
1 21215-0020 led within 72 hours at bygiens. Per than "natural", or rt, the Medical Exam	mpiered	15. Decedent's Ec (Specify only highast gra	de completed) College (1-4or 5+)	(Giva I	lent's Usual Occup kind of work dona DO NOT use retire SEW1fE	pation during most of working d)		16b. Kind of Bu	usiness/Ind	fustry
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S should by and Mente and Mente is marked aumatic or To F	-	9a. Informant's Name/Ralationship (Type, Print)	19b. Meilin	g Address (Street	and Number or Rura		, City or Town,	State, Zip	Code)
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Baltimore, Maryland : semit. Pages 1 and 2 should be filed between of Heath and Mentel thy reportant: if them 27 is marked other iny injury or other traumatic event, and	2	0e. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 2)	Removal from Stete	Place of Dispos cematary, cram	sition (Nama of natory or other pla alley Me	ce)	Data	20c. Location - Timoniu	City or To	.,
Baltim permit. Par Department important: any injury.	2	21. Signetura of Funaral Service Licen			Name and Addre	ass of Facility			<u> </u>	21215
(68760, nrificate be executed ing physicien end as the burist-transit	ourcal Examiner	Sequentially list conditions, any, leading to immediate ause. Entar Underlying ause (Disease or injury hat initiated events asulting in death) Last	DILATE	or as a consequence or as e consequence or as e consequence or es a consequence or es a consequence or es a consequence or es a consequence or es a consequence or es a consequence or es a consequence or es a consequence or es a consequence or es a consequence or es a consequence or es a consequence or es a consequence or establishment or establ	PARDI	DIAL Mes	ANT +	DiseA	be	8 yrs
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aw requir	- Parada						24a. Wes a perform		ev	ara autopsy findings ailabla prior to mplation of ceusa death?
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clan: clan: entific ector.	2	Was cesa rafarred to medicel examinar?			100	26. Placa of Death	(Check only on	a)		
Phy a la la la la la la la la la la la la l	-	7. Manner of Death Natural 5 Pending	28e. Data of Injury (Month, Day Year)	ER/Outpatient 28b. Tima of Injury	28c. Inju Wo		me 5 Reside 28d. Describe ho			y)
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To the Hospital within 24 hours a To the Funeral I completely filled Medical Ce		9a. Cartifier (Check only one) 2 Medicat Exert	ysician: To the best of my kno liner: On the basis of axamina and manner steted.	wledga, death ition and/or inv	occurred et tha ti	ma, data and place, a	and dua to tha ce	euse(s) and ma	nnar as s	ated. tha ceuse(s)
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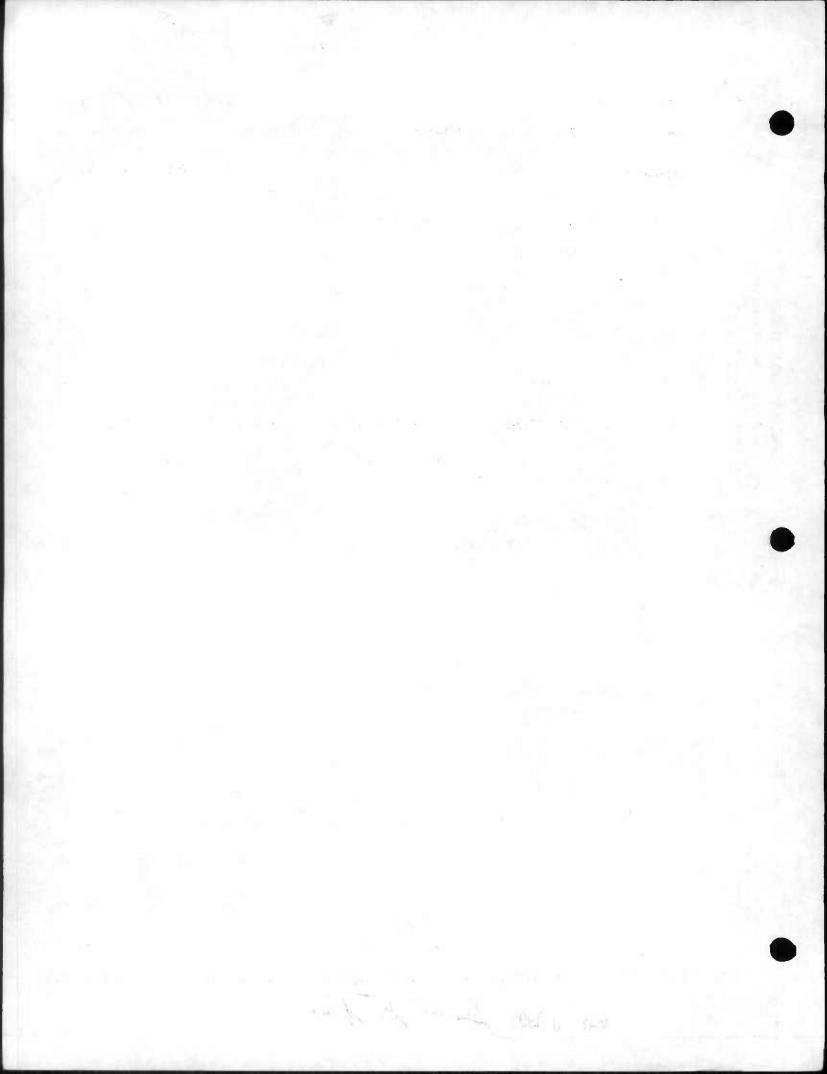


State Registrar 31. Date filed (Month, Day, Year)

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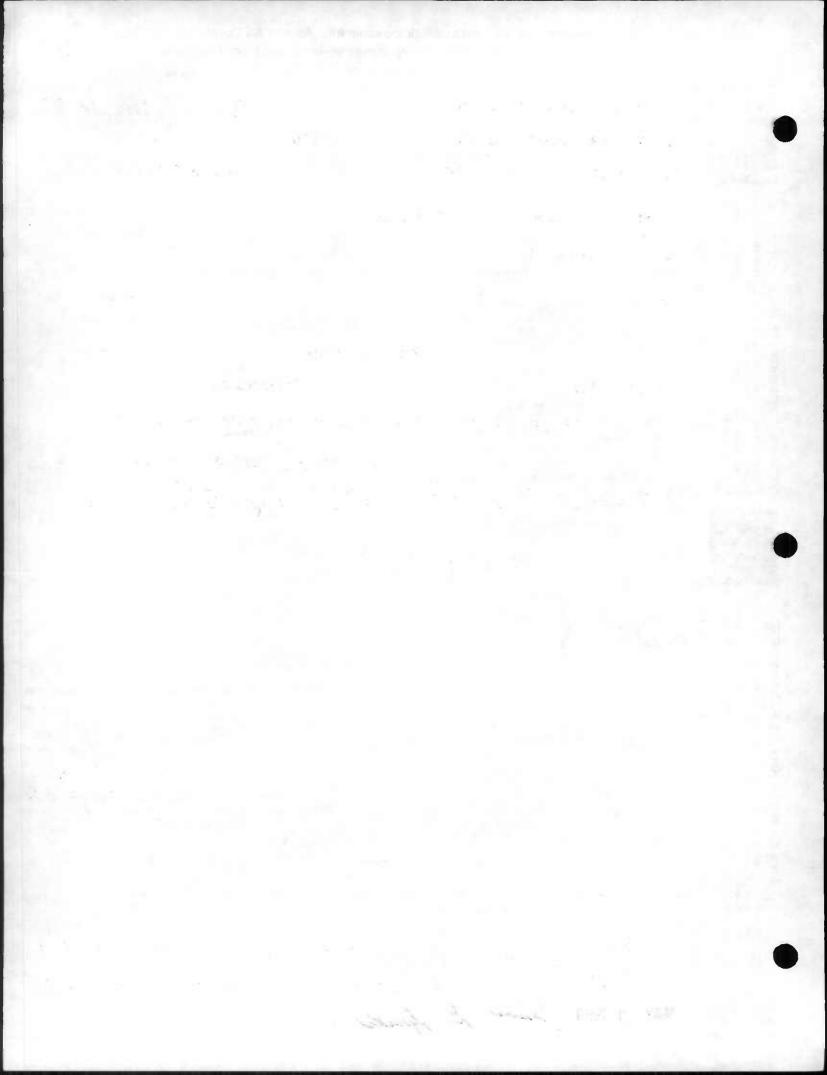
32. Registrar's Signature



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Examiner	4e Fecility Nama							4b. City, Town, o			ounty of De	eth
				PICE AT N			1 1/11 1 - 4 3/	BALTIMO			N/A	
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arrer dearn with the maryland w items 23s or 28s-f show where must be notified at Funeral Director	10e. Street and No.	umber stend S	Stree	et			10f. Zip Coda 2123	30		10g. Citize		Country?
or its		rried 2 Mar	rried	2. Wes Decedant Armed Forcas' 1 ☐ Yas 2 ☐ If Yes, Giva X Yaar or Datas:	?] No		Was Decedent of If Yas, specify Cub 1☐ Yes 2♥ No		Specify Yes or N irto Rican, atc.)		. Race - Ar Black, WI pecify:	narlcen Indian, nita, atc. white
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Department of Important: If any injury or once.		5 Othar (S	Spacify)			dar Hi	ill Cemet	cery	5/4/99	Brook	lyn I	Park, Md.
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	State of Maryland / Department of Health and Mental Hygiene

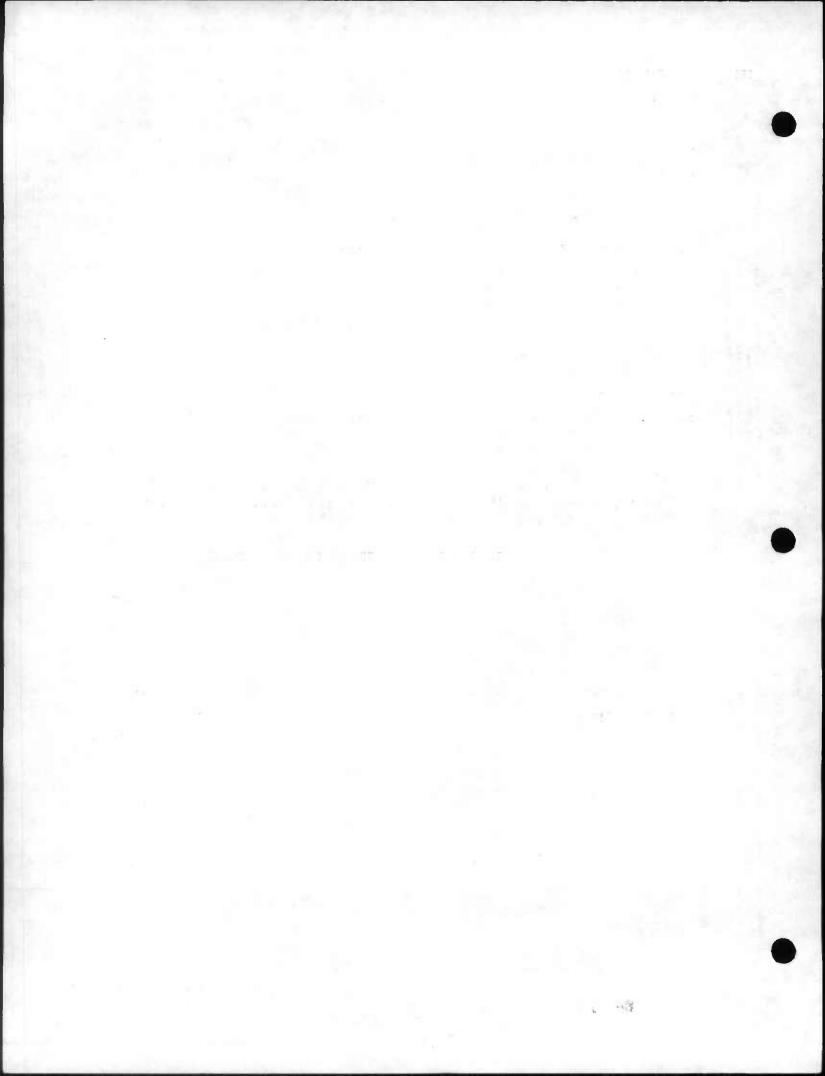
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П	Physicia		1. Decedant's Nam KARE		Last)		CRA	WFORI	D		2. Data of De Month	Day	Year	3. Tima of Death	
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	۶ کا		Usual Rasidance o	f Decedant 10b. County		1.	I0c. City, Town or L	acation					1404	1	
	ahov	7	MD	NA			BALTIM						100.	Inside City Limits 1 √ Yas 2 No	
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	nd 21215-0020 so filed within 72 hours after tal Hygiene. d other than *natural; or its event, the Medical Examine	by Funera	11. Marital Status Will Nevar Marr 3 Wildowed	ried 2 Marrie	Armed 1 ☐ Ya If Yas,	Decedani Ev I Forces? as 2 No Giva or Datas:	ar in U,S. 13.	Was Deced If Yas, spec		lispanic Origin? (S an, Mexican, Puerl Specify:	nanic Origin? (Specify Yes or No- Mexican, Puerto Rican, atc.) 14. Race - American India Black, Whita, atc. Specify: Specify: BLACK				
0-0				15. Decedant's	Education		16a. Dece	edent's Usua	al Occup	pation		16b. Kind of B	usiness/Indus	itry	
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0	0 0 - 2			position Cramation 5 Other (Spe		om Stata	20b. Place of Disp cematary, cre WOODLAWN	matory or o	other place	RY	Data 4-30-99	20c. Location BALTI	City or Town		
Balt	permit. Page Department of Important: If any injury or page.		21. Signatura of Fu	ms	BJ	lar	M 4	ARCH 300 V	FUI WABA	NERAL HOASH AVE	. BAL	TIMORE,	MD 2	21215	
	Physician /Medical Examiner	ler	sheck, or has Immediata Causa disaasa or condition rasulting in daath)	(Final		RTENSIV	E ATHEROSCL use to (or as a conse	EROTIC	CARD				In	tarval Between nset and Death	
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B	deam centre en estendin ed for use	Physiclan/Medic	Part II. Other signif	ficant condition	ds contributing to	o death but	not rasulting in tha	underlying c	ausa giv	ven in Part I.	23b. Did	tobacco use co	ntribute to th	ne cause of death:	
S, P	requires met me der een signed by the e hould be detached f	by Phy	DIARETS ME	ELLITUS							10	Yes 2□ No	3 Probet	oly 4⊠Unknow	
Record	ete hes been si pege 2 should	Completed									24a. Was perfe	an autopsy ormed?	availa	autopsy findings able prior to eletion of cause ath?	
= F	cete he										1.图	Yas 2□No	LECTY	'es 2□ No	
Vital	is certificate director, per	Be	25. Was casa rafar axaminar?		Hospital:				Oth		ath (Check only	one)			
o	After this funeral di	ition: To	1 ☑ Yas 2☐ 27. Mannar of Deat 1 ☑ Natural 2 ☐ Accident		28a. Da	☐ Inpatient ata of Injury fonth, Day Y	28b. Tima o		28c. Injur Wor	4 LI Nursing F	T	dence 6 SOth how injury occur			
	within 24 hours after death. To the Funeral Director: A completely filled in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicida	6 Could no datarmin	ed Zoa. Fie							28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)			
	within 24 hours at To the Funeral D completely filled	edicai	29a. Cartifiar (Check only one)	1 Certifying 2 Medical Es	caminer: On the	tha best of r a basis of a annar state	my knowledge, daal kamination and/or ir d.	th occurred anvastigation,	at the tir , in my o	me, data and place pinion, death occu	e, and due to tha arred at the tima,	cause(s) and m data and place,	annar as state and dua to th	ed. na cause(s)	
	To the complete of the complet	Ž	29b. Signatura and	titla of certifiar		1	1.20	290	c. Licens	e number		29d. Data signe	d (Month, Da	y, Year)	
			30. Nama and addr	ess of person w	ho complated ca	ausa of daa	th (Yam 23a) (Type	P Print)	0	.C.M.E.		April 2	6, 199	9	

State Registrar

DHMH 16 Rev 6/95

Radentz,
32 Registrar's Signatura

111 Penn Street, Baltimore, Maryland 21201



Physician /Medical **Examiner**

bunal-trensit

director, page 2 should be datachad

à

Physician/Medical

Completed by

Be

2

Certification:

Medical

and

The law requires that the death certificate be executed

P.O. Box 68760,

of Vital

Division

Attending Physician:

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Aftar this in by the funeral

death.

s after death

To the Hospital within 24 hours a To the Funarel Completaly filled

Physician

/Medical

Examiner

10a Stata

Funeral

Director

28a-f show

Items 23e or 28a-f shortment be notified at

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"neturel".

tel Hygiena.

. Pages 1 end 2 should be fili-mant of Health end Mentel H-lant: If item 27 la marked oth-jury or other traumatic even

Depertment of Important: If any injury or once.

traumatic event, the Medical Examiner

filed within 72 hours after death with

21215-0020

Baltimore, Maryland

Director

Funeral

þ

Completed

Sequentially list conditions, if any, leading to immadiate causa. Entar Undarlying Causa (Diseasa or injury that initiated events rasulting in death) Last

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uaa contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown

24e. Was an autopsy performad?

24b. Wara autopsy findings availabla prior to completion of causa of death?

26. Placa of Daath (Chack only ona)

21202

25. Was cese rafarrad to madical axaminer? 1 ☐ Yes 2 No

1 Inpatiant 2 ER/Outpatient 3 DOA

28b. Time of

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28c. Injury at Work? 1 Tas 2 🗆 No

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

28f. Location (Straat and Number or Rurel Routa Number, City or Town, Stata)

29a. Certifiar

27. Mannar of Death

1 Natural 2 Accidant

3 Suicida

4 Homicida

1 Certifying Phyaiclan: To the best of my knowledge, daath occurred et the tima, data and plece, end due to the cause(s) and menner es steted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the ceuse(s) and menner stated.

29b. Signatura and title of certifier

5 Panding

Invastigation

6 Could not be datamined

29c. Licansa number 0853

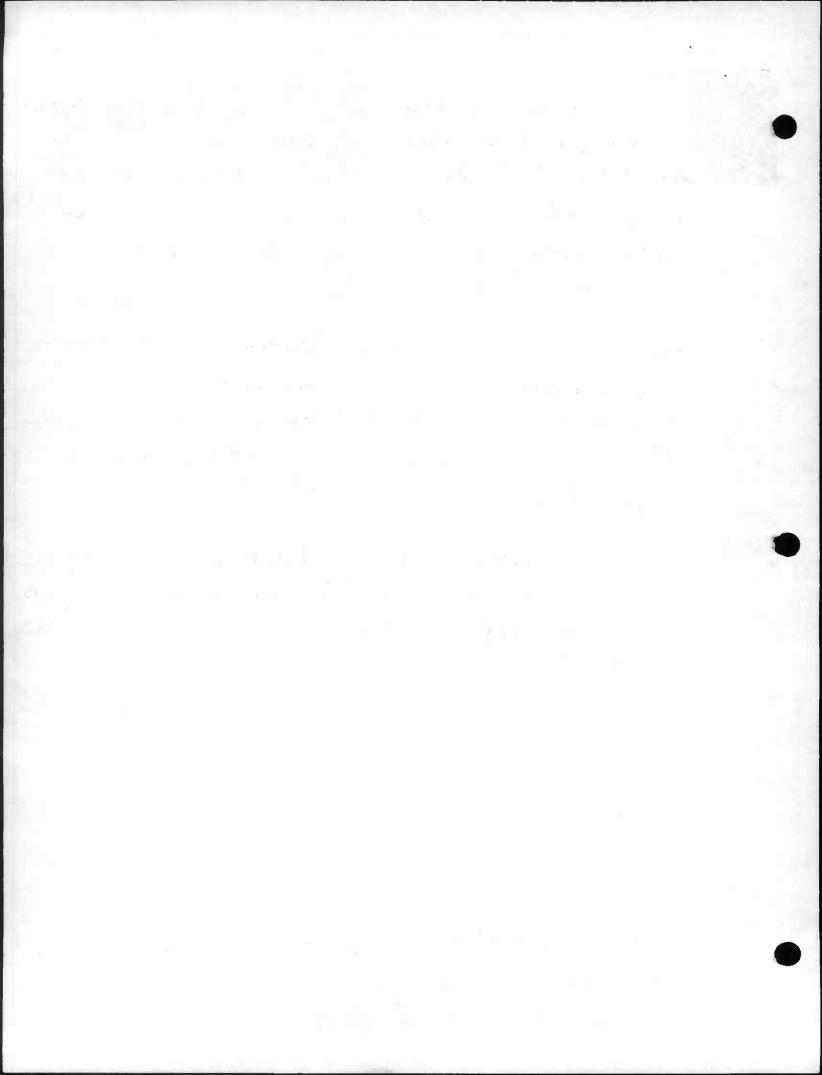
on who completed causa of death (Item 23e) (Type, Print)

Pau Jace IMORE

31. Data filed (Month, Day, Year) State

32. Registrar's Signatura

Registrar

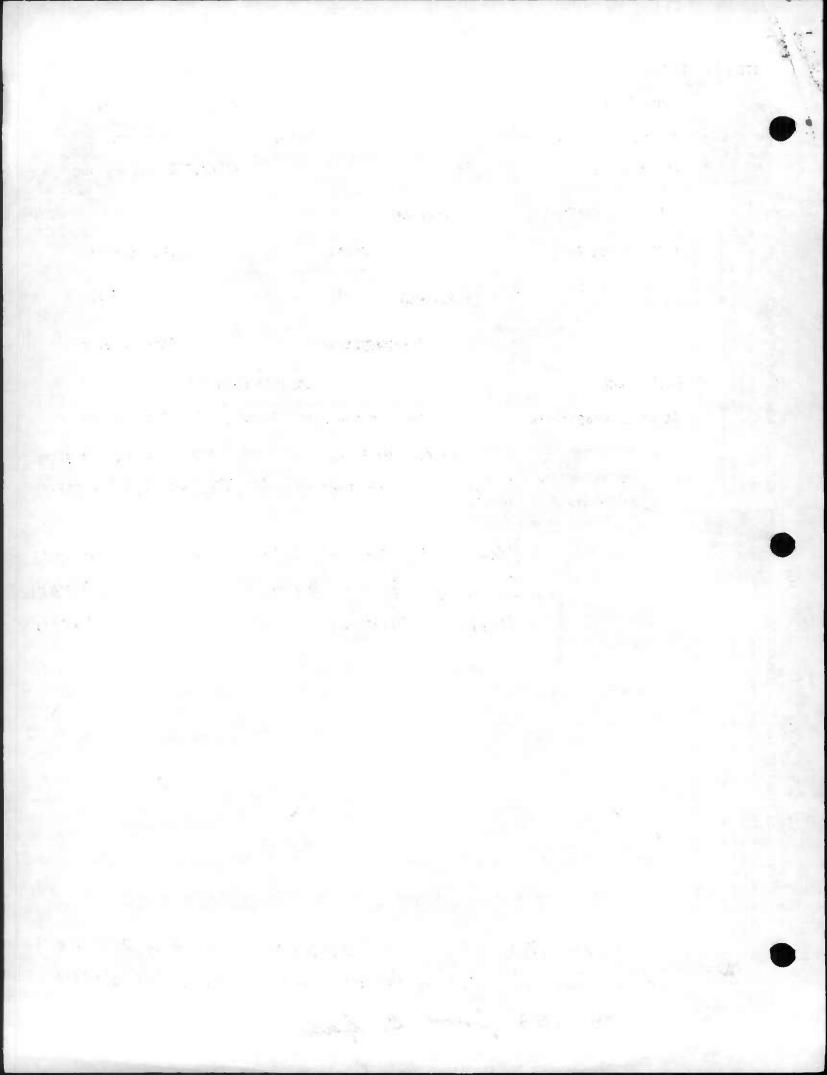


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	State of Maryland / Department of H Certificate of L		Reg. No.
Physician	1. Decedent's Neme (First, Middle, Last)	2. Date of D Month	Dey Year
/Medica	Cece ic Dyer 4a Facility Neme (If not institution/give street and number) 4	b. City, Town, or Location of Des	28 1999 4:10 PM
Examiner		Bakinore	ath 4c. County of Deeth N/A
Funeral Director	Church 105p/fa 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 213-03-3727 1□ M 2XF 96 Yrs. Months Days	If Under 24 Hrs. 8. Date of B	
1 1	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
death with the Maryland	Maryland N/A Baltimore		1∭ Yes 2□ No
or 28s-f	10. Street and Number 10f. Zip Code		10g. Citizen of What Country?
1 E	101 N. Bond St. 21231		United States
_ 3 4 S	1. Marital Status 1. Marital Status 1. Was Decedent Ever in U,S. Armed Forces? 1. Yes 2. No 1. Was Decedent of Hi If Yes, specify Cubar 1. Yes 2. No 1. Yes 2. No 1. Yes 2. No	spanic Origin? (Specify Yes or N n, Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian, Bleck, White, etc. Specify: White
Maryland 21215-0020 22 protecting within 72 hours at the first part forms of the first part of the fir	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 12 15. Decedent's Education (Give kind of work done of life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) EXECUTIVE SEC	uring most of working)	16b. Kind of Business/Industry insurance
D 1931	17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First, Middle	
ylar de la	John J. Dyer, Sr.	Cecelia B.	Baker
[] [] [] [] [] [] [] [] [] [] [] [] [] [19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street &		nber, City or Town, Stete, Zip Code)
1 miles		St., Suite LL	3B Baltimore, MD 21230
To a series	1 \(\) Burial 2 \(\) Cremetion 3 \(\) Removal from Stete 4 \(\) Donetion 5 \(\) Other (Specify) Cemetary, cremetory or other place Lorraine Park Cemetary.	tery 5/1/99	20c. Location - City or Town, Stete Woodlawn, Maryland
Ball Department important	21. Signature of Funerel Service Licensee 22. Name and Addres	s of FecilitMitchell—W 6500 York Baltimore,	Wiedefeld Funeral Home, Inc Rd. MD 21212
47.	23a Ant Enter the disease, or complications that caused the deeth. Do not enter the mode of dying mock, or heart feilure. List only one cause on each line.	g, such es cardiac or respiretory	errest, Approximete Intervel Between Onset end Death
Physician /Medical Examiner	Due to (or es a consequence of):	ction	24 hars
Box 68760, leeth certificate be executed after use as the burial-transit clan Medical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):		
Box 6 deeth certification of for use a	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	on in Part I 23h Di	d tobacco use contributa to the causa of death?
P.O. the the detached by the d	Cardionyopothy Hypertonsin		Yes 2 No 3 Probably 4 Unknown
requirements	Regarding and [Fachere; Asysto)		es en eutopsy rformed? 24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
Vitai Reciclan: The law certificate has become!		10] Yes 2☑No 1 ☐ Yes 2☑No
Vitai Fellan: The certificate irector, pag	25. Was case referred to medicat examiner?	26. Place of Deeth (Check only	y one)
T digital	1	4LI Nursing Home 5LI He	sidence 6 Other (Specify) e how injury occurred
Division of stending P as the redeath of the tuner death of the tuner certification:	1 Netural 5 Pending (Month, Day Year) Injury Work	Yes 2 No 28f. Location	n (Street and Number or Rurel Route Number, Town, State)
Certification of the Control of the			
To the Hospital or within 24 hours after completely filled in Medical Cert	29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the tim (Check only one) Medical Examiner: On the basis of examinetion end/or investigation, in my open and manner stated.	pinion, death occurred et the time	e, date end piece, end due to the ceuse(s)
or view	29b. Signeture and tilling of capitier	number	29d. Date signed (Month, Day, Year)
	There, May D46	120	april 28, 1999
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) F DeLeon 98 N Broadway, Baltim	ore, 000 Z	1231
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature		,

STATE OF STATE BEEF WAR

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM: 19B PER F.H. G771 5-6-99 WR. Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death 5 Pm Month **Physician** Joseph John Drago 1999 mar /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of BelAir BelAir Harford 7. Aga (In yrs. last birthday) 81 Yrs. 8. Data of Birth 03/24/1918 5. Social Sacurity Number 6. Sax 1 M M 2 □ F if Undar 1 Yaar | if Undar 24 Hrs. Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours Min 218-09-7731 Maryland Director Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City. Town or Location 10d. Insida City Limits 28a-f ahow 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Workel Examiner must be incitified as MD Harford Edgewood 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 72 hours after deeth with 1907 Hanson Road 21040 United States Funeral 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Dacedant Evar in U,S. Armed Forcas? 1♥1 Yas 2□No If Yas, Giva Yaar or Datas:1942-1946 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritai Status 1 Navar Marriad 2 XMarried 1 ☐ Yas 2 No Specify: Specify: White þ 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratived) Restaugant()Wner 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada complated) oe filed within 7 el Hygiena. Elementary/Secondary (0-12) Collega (1-4or 5+) Food Service 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) 12 should be fill h and Mentel H is marked out Jack Drago Loretta Pusateri 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Typa, Print) permit. Pages 1 and 2 sh Department of Haalth and Important: If Item 27 is rr any injury or other traun Sarah-L. Drago/Wife 1907 Hanson Road, Edgewood, Maryland 20b. Place of Disposition (Nama of camatary, crametory or other place)
Gardens Of Faith 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 Cramation 3 Ramoval from Stata 05/05/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licanses 22. Nama and Addrass of Fecility 22. Nama and Addrass of Fecility Leopard Jorge Ruck Inc. 121214 Krishna O 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Myocardist Infunction Immediata Causa (Final disaasa or condition resulting in daath) /Medical Seconds **Examiner** Physician/Medical Examiner ettending physician and for use as the buriet-transit tha death certificate be axecuted Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Lest signed by the e 23b. Did tobacco usa contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No that by OSEPh The law requires 24b. Ware autopsy findings available prior to complation of causa of daath? Completed 24a. Was an autopsy parformad? s ueeq this certificate has 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No director, 25. Was casa rafarrad to madical axaminar? Be 28. Pleca of Death (Chack only ona) Hospital: 1 | Inpatiant 2 | ER/Outpatient 3 | DOA Othar: 4 Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 Yas 2 No Certification: To of funerel 27. Magnar of Death 1 Natural 2 Accidant 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Yaer) 28b Time of 28c. Injury at Work? After 5 Panding investigation Attending Division 1 ☐ Yes 2 ☐ No death. at or Attendil s efter death. ii Director: A sd in by the fu 6 Could not be datarminad 3 ☐ Sulcida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) filled in by 4 | Homicida To the Hospital of within 24 hours of To the Funeral D 29a. Certifier 1 Cortifying Phyaician: To the best of my knowledge, daath occurred at tha time, deta and plece, end due to the cause(s) end mennar es steted. edicai 2 Medical Examiner: On the besis of axaminetion end/or invastigation, in my opinion, daath occurred at the time, date end place, end due to the cause(s) and manner stated. (Check only one) 3 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of cartifia 29c. Licansa number 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Bil Air Muryland 21014 Scott North AVENUT HULWEL 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State Registrar **DHMH 16 Rev 6/95**



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Francis Joseph DeMoss 01, 1999 6:15 PM May 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, give street and number) 4c. County of Death Gilchrist Center Towson Baltimore Co. If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number if Under 1 Year Birthplaca (Stata or Foraign Country) 7. Age (In yrs. last birthday) Months Days 1X M 2 F Yrs. 219-18-3471 75 February 29,1924 | Baltimore, Maryland Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 X No Maryland Baltimore Co. Timonium 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21093 109 Country Lane United States of America 14. Race - American Indian, Black, Whita, etc. 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 2 X No Specify: Specify: White 3 □ Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Construction Manager Construction 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fathar's Name (First, Middle, Last) H. Bradford DeMoss Julianne McDonough 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Mrs. Melvina DeMoss(Wife) 109 Country Lane Timonium, Maryland 21093 20b. Place of Disposition (Nama of cametary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 5/05/1999 Baltimore, Maryland Druid Ridge Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Service Licansaa Jeffrey L. Gair 22. Nama and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 ave O 23a. Part. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only due cause on each line. Approximata Interval Between Onsat end Deeth Immediata Cause (Final disease or condition resulting in death) Concer Due to (or es e consequence of) Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury Dua to (or as a consequence of): that initiated avants rasulting in daath) Last Dua to (or as a consaguanca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No 24a. Was an autopsy performad? 24b. Wara autopsy findings available prior to complation of causa of daath? 20 No 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical axaminar? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) Appect 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 5 Panding 1 Naturat 1 ☐ Yas 2 ☐ No investigation 2 Accidant 6 Could not be datermined

Certifying Physician: To the best of my knowladga, daath occurred at the tima, data and place, end due to tha causa(s) and mannar as statad.

Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the cause(s) and mannar stated.

29c. License number

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

Balto. MD

29d. Date signad (Month, Day, Year)

Delhoss, Frankly willigh U.15 PM ettending physicien end for use es the burial-transit law requires that the death certificate be executed 98 ed by the detached signed by t been sig certificate has b director, this funeral

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Physician/Medical Examiner

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Completed

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Certification:

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3 Suicida

29a. Cartifian

4 Homicide

(Check only

29b. Signature and the of certifie

30. Name and address of person

Funeral

Director

Pages 1 and 2 should be filed within 72 hours effer death with the Maryland neat of Health and Mental Hyglene. Intel if I fem 27 is marked other than "natural", or items 23e or 28e-f show mit. If I tem 27 is marked other than "natural", or other traumatic event, "ne Medical Exempter man be notified at uny or other traumatic event," ne Medical Exempter.

Important: If Its any injury or o once.

Physician

/Medical

Examiner

or Attending ä 124 hours a To the Hosp within 24 hor To the Fune completely fi

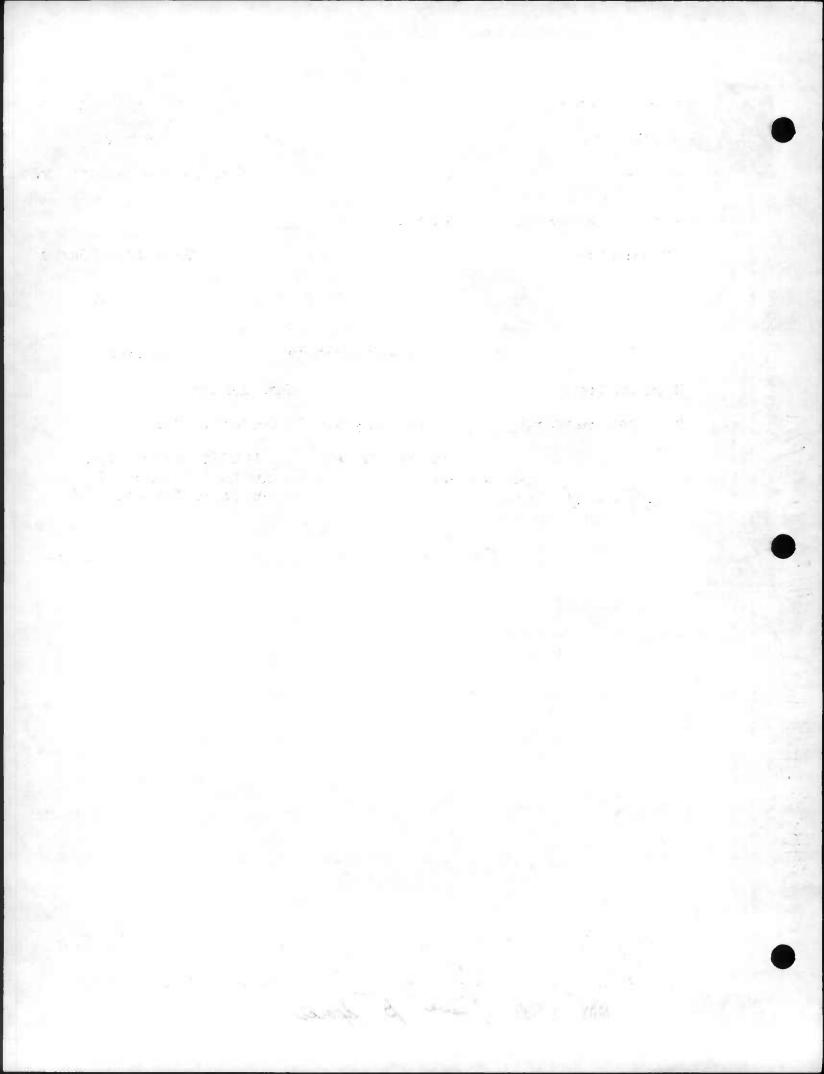
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who cop platad causa of the (Itam 23a) (Typa, Print)

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

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N. Chales

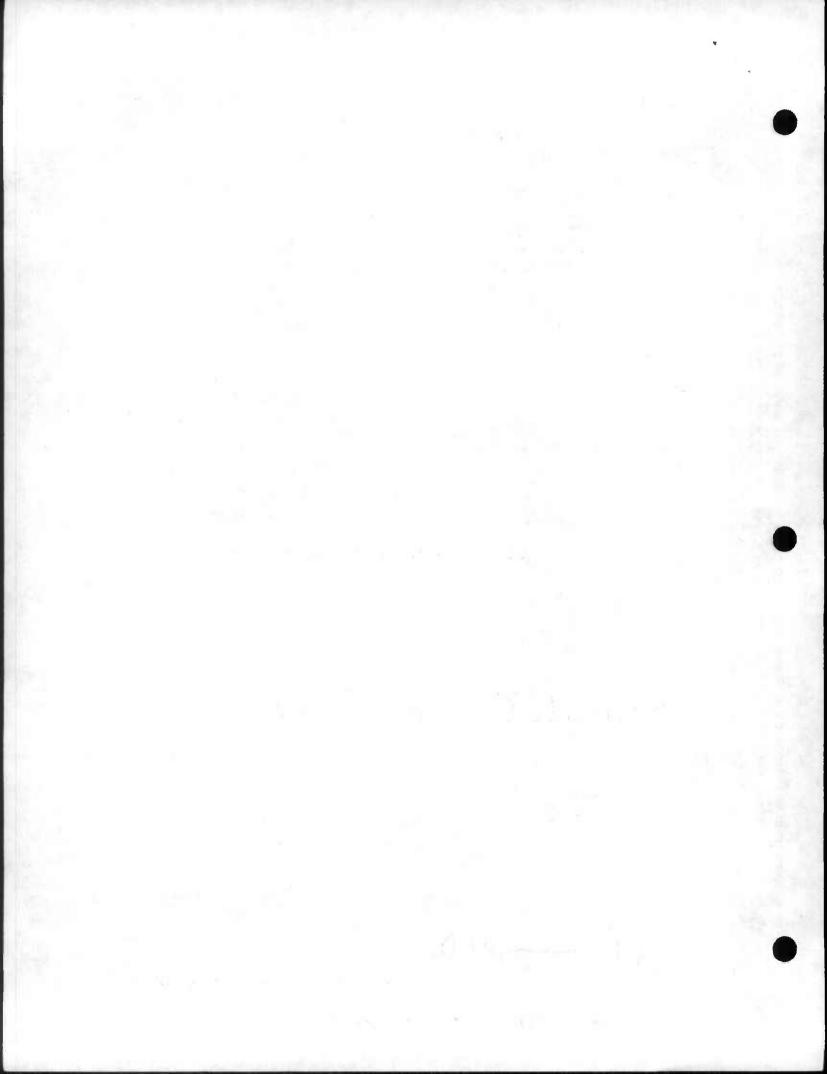


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. L 2 2 6 State of Maryland / Department of Health and Mental Hygiene

EVANS JR.			Certifica	te of Death	R	eg. No.	
	1. Decedent's Name (First, Middle, La			Ph/2 = 3	2. Dete of Deel Month	lh	3. Time of Deeth
Physician /Medical	William Eun	gnis, SR.			APRIL	24, 199	9:25 PM.
Examiner	4a Facility Name (If not institution, give	a street and number)		4b. City, Town, or	Location of Death	4c. County of	Death
	2503 VIOLET A			BALTI		1	11
Funeral Director	210	3ex 7. Age (In yrs. 67	Vrs. If Under Months	er 1 Yaar If Undar 24 Hr B Deys Hours Mir		Year) 93/ 0	Birthplace (State or Foreign Country)
D .	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location			/	10d. Inside City Limits
deeth with the Maryland ms 23s or 28s-f show rmast be notified at	Havylan ~//	9	BAHMER			Og. Citizen of Who	1≜ves 2□No
fier deeth with the Me from 23e or 28e-f from must be notified Funeral Directo	2503 Violet		502	12/5		USA	
020 urs efter error to by Full	11. Merital Stalus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 Yes 2 Who If Yes, Give Year or Dates:	if Yes, sp	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue 22 No Specify:	specify res or No- rto Rican, etc.)	Bleck,	American Indien, White, etc. Black
5-0 72 h 72 h natur	15. Decedent's En (Specify only highest gra		16a. Decedent's Us (Give kind of w	uel Occupation ork done during most of w use retired)	orkina	16b. Kind of Busin	United States
1 21215-0 ed within 72 ho tygiene. The meture in the medical completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Capistric		er	Private	Business
be filed to the read of the re	17. Father's Name (First, Middle, Last	and the second s	100	18. Mother's Ne	eme (First, Middle, I	Maiden Sumame)	
Viar ould be Mente mrked atte ev	William Eum	-s, SR.		nann	18 Flory	isen	
	19a. Informant's Name/Relationship (/					ate, Zip Code) 3/3/
2 2 2 2	BRYBBYS EUANS / 20a. Method of Disposition	WIR		J. Culdspril			
Pege Pege nent: M	1 Burial 2 Cremetion 3 4 Donation 5 Other (Specif	y) Vo	Place of Disposition (No cometery, cremetory or SHE!! Men	restial Como	4/27/99	DUNDA	ty or Town, State (k, Harylonso
Balting permit. Pe Department important: eny injury ance.	21. Signature of Funeral Service Lices		22. Name of 50 40 BOLA	end Address of Fecility Co RELISTONS You UNIVE MA	HATHIN ZIZI	- HARR	11 Feneral Hene
	23a. Part 1. Enter the disease, or comsheck, or heart failure. List only	plications that caused the deet one cause on each line.	h. Do not enter tha mo	oda of dying, such as cardi	ac or raspiratory arm	ast,	Approximata Interval Between
Physician (Medical	Immediate Course /Final						Onset end Death
/Medicat / Examiner	Immediate Cause (Final disease or condition resulting in death)	a Arterioscle	rotic Card	iovascular D	isease		1
5		Due to (c	or as a consequence of):			
owecuted in end iei-transit Examiner	Sequentially list conditions	bDue to (c	or as a consequence of):			
58760, loste be executed physician and sith burlei-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
rifficate be and physician es the burde	that initiated events resulting in death) Last						
# 00 E							
deeth cert cert cert cert cert cert cert cert							
P.O. Box et the deeth certification of the etending eteched for use	Part II. Other algnificant conditions of	ontributing to death but not res	ulting In the underlying	cause given in Pert I.	71111/1112		ibute to the cause of death?
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Records, he lew requires to the been signed to 2 should be ompleted by					24a. Was a		24b. Wara eutopsy findings available prior to
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The level page 2					1 🗆 Y	as 2 No	1 Yas 2 No
r Vital Freden: The certificate director, peg	25. Was case referred to medical examiner?			26. Place of D	eath (Check only on	10)	
- × = 0	tio ves 2□ No		ER/Outpatient 3 0	OOA Other: 4 Nursing	Home 5 A Reside	ence 6 Other	(Specify)
After II funeration:	27. Manner of Death 15☐(Natural 5 ☐ Pending	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe ho	ow injury occurred	
Vision Attending r deeth. ector: Afte by the fune	2 Accident investigation 3 Suicide 6 Could not b		М	1 Yes 2 No	206 Leastine (C	tonat and Mirmbar	or Dural Davida Number
DIVISION of the or Attending P is effer deeth. el Director: After is of in by the funerised in by the funeric Certification:	4 ☐ Hornicide determined	28e. Place of Injury - At he building, etc. (Specify	ry, office	City or Town	n, State)	or Rural Route Number,	
DIVISION O To the Hospital or Attending Ph Within 24 hours after describe To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Ph (Check only one) 2 X Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occurre- tion and/or investigation	d at the time, date and place on, in my opinion, death occ	e, and due to the courred at the time, d	ause(s) and menn ate and place, and	er es stated. d due to the cause(s)
Methin Somple	29b. Signature and title of certifier		2	9c. License number	2	9d. Date signed (Month, Dey, Year)
->-0	1 Pesta	min. M.D		O.C.M.E.		APRIL 2	5, 1999
1	30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Print)				14 0 12
1				book Dalki	nome Man	7 7 21	004
	JOSEPH PESTANER	11.17.	TII Peilli 2	treet, Balti	nore, Mar	Araug St	201

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death AMENDED #5 PER FH G771 5/21/99 AH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month, Estrella 1999 **Physician** 6:44 AM Apri Alberta 30 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Prince Hospital George's Laurel Laurel If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) if Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** Deys Months 1 M 20 F 88 11/19/1910 **Director** 026-05-7351 MA Usual Residence of Decedent with the Marylend 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at Md 1 XYes 2 No Prince George Director Laurel 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 9001 Cherry Lane 20708 Funeral USA deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status 12. Was Decedent Ever In U,S. Armed Forces? Black, White, etc. filed within 72 hours efter 1 Yes 2 No 1 Never Married 2 Married Specify: white altimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 2 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Etementery/Secondary (0-12) Cotlege (1-4or 5+) Health 6 .. Peges 1 and 2 should be filed w tment of Health and Mental Hygia tant: If Item 27 Is marked other ti jury or other traumatic event, In-Nurse Aide other 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Alphonse Dube Rosalia Forgette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6204 Wild Swan Way, Columbia, Md 21045 Claire Destres/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Notre Dame Cemetery 05/03/99 Falls River, MA 22. Name and Address of Facility 21. Signeture of Funeral Servica Licansee Sterling-Ashton-Schwab Funeral Home, Inc. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** CEPEBROVASCULAR ACCIDENT /Medical Immediate Ceuse (Final ACUTE disease or condition resulting in death) Examiner Due to (or es e consequenca of): Examiner ician end buriel-trens Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760, ettending physician for use es the burie certificate be Physician/Medicai Due to (or as e consequenca of) es 1 ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? ATMAC FIBRICATION 1 | Yes 2 | No 3 | Probably 4 | Unknown Division of Vital Records, À 8 HUPERTENSION 24b. Were autopsy findings available prior to comptetion of cause of death? 24a. Wes an autopsy performed? Completed page 2 s certificate hes 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ENOutpatient 3 ☐ DOA To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 1 Matural 5 Pending investigation s efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 6 4 Homicide To the Hospital within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and pleca, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end manner steted. 29a. Certifier edical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 99 124997 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8317 Luis A. CASAS LAUREL MD 20707 CHERRY LANE

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DHMH 16 Rev 6/95

State Registrar 31. Date fited (Month, Day, Year)

MAY

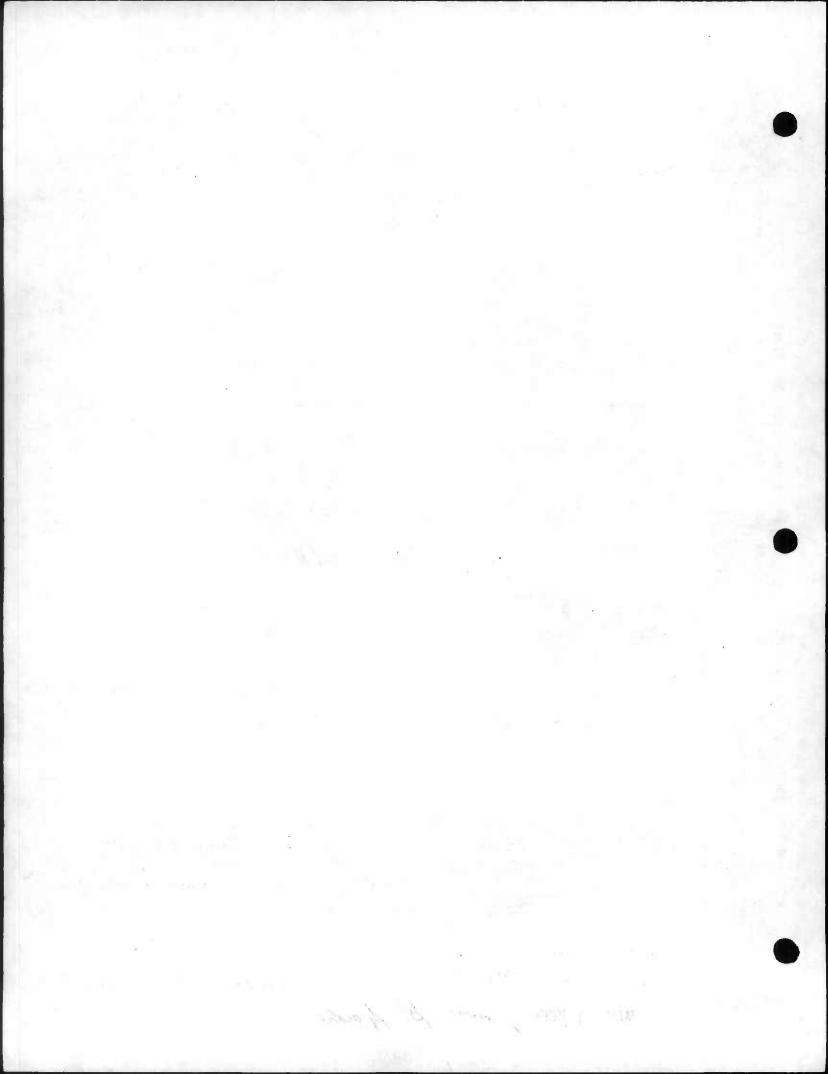
3 1999

32. Registrar's Signature

SOLE BENEFITS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 4 2 2 8

. 71			Certificate of	of Death	Re	g. No.		
	1. Decedent's Name (First, Middle, La	st)	1 80 5		2. Date of Death Month		Yeer	3. Time of Death
Physician /Medical	Carlton Gregory	Finch	- 10 July 10		APRIL		999	12:43 A
Examiner	4s Facility Name (If not institution, given MARYLAND SHOC	re street and number) K TRAUMA		4b. City, Town, or I BALT'IMOR		4c. County	of Death	
Funeral Director		Sex 7. Age (In yrs. las	t birthday) If Under 1 Ye Yrs. Months De		8. Date of Birth (Month, Day, Nov. 9,	Year) 1974		lece (Stete or Foreign try) y land
28a-f show outfled.at ector	10a. State 10b. County		Town or Location				10	0d. Inside City Limits
or 28a-fa be notifie Directo	Maryland N/ 10e. Street and Number	A D	altimore 101. Zip Cod	le	10	g. Citizen of V	Vhat Coun	try?
at be	1827 Eagle Str	eet		21223		United	l St	ates
at, or have 23e or 28e-f show Examiner must be notified at by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent	of Hispanic Origin? (S cuban, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American India Bleck, White, etc. Specify: Black 6b. Kind of Business/Industry		etc.
nt the Medical Ex-	15. Decedent's E (Specify only highest gn Elementary/Secondary (0-12)		16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re	cupation ne during most of wor tired)	tking			lustry
Com	12		Clerk			Food		ice
Be s	17. Father's Name (First, Middle, Last			18. Mother's Nam Diane	ne (First, Middle, N Bishop	laiden Sumam	ie)	
To	Carlton Ray Find	Type, Print)	19b. Mailing Address (Str	eet and Number or Ru	ıral Route Number,			
100	Carlton Ray Fi		1827 Eagle			20c. Location -		
injury or o	1 Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (South	Removel from State	udon Park Ce	place)	5/5/1999			Maryland
any in	21: Signatore of Funeral Service Lice	1500		funeral Ho phur Sprin		butus.N	farv1	and 21227
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ng physician and sas the burlat-banait Medical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	¢	s a consequence of):					
tached for use	Part II. Other eignificent conditions of	d	ng in the underlying cause	given in Part I.	***************************************		ntribute to	the cause of death?
should be leted by					24a. Was ar perform		avi	ere autopsy findings allable prior to impletion of cause death?
page 2 Comp					11/v	s 2□No	16	Yes 2 No
ractor, pa	25. Was case referred to medical examiner?			26. Place of Dec	ath (Check only on	n)	-	
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Me	290. Signature and tiple of certifier Theselve M	1 King mo		ense number .C.M.E		APRIL		
	THEIDOREMIKE		111 Per	n Street,	Baltimor	re, Mar	yland	21201
State Registrar	31. Date filed (Month, Day, Year) MAY 3 19	99 Segistrar's Signatur	G. Spark	N				



Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month MA4 Year 1999 10:45 AM ama Francis 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Baltimore Deaton Medical Center 8. Date of Birth (Month, Dey, Yeer) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Deys 1⊠M 2□ F Months Hours Min Virginia Yrs. 81 105-12-9014 Usuel Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 611 S. Charles Street 21201 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates: WWII Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14 Race - American Indian 11. Meritel Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Cotlege (1-4or 5+) Etementary/Secondary (0-12) Golf Course Gardner 12 18. Mother's Name (First, Middle, Maiden Surname) Sophia Yancie 17. Fether's Name (First, Middle, Last) Andrew Francis 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 5138 Beaverbrook Road, Columbia, MD 21044 Raymond C. Francis (Son) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 5/5/99 Owings Mills, MD MD Veterans Cemetery 22. Name end Address of Fecility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Liceria 1630 Edmondson Avenue, Catonsville, MD 21228 Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cerdiac or respiretory errest, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Finel proumoni a 4 days disease or condition resulting in death) Due to (or es e consequence of): 104-5 Mypostonsian Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of): 104-6 mollitus Dioheles Due to (or es e consequence of) disem-0 144) (my Chrmie obstrictic 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yae 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cspin-e Fracture 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? completion of cause of death? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Examine Physician/Medicai

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Completed

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Certification:

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State

Registrar

Physician

/Medical

Examiner

Funeral

Director

show

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Is marked othe

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once.

Physician /Medical

Examiner

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To the Hosp within 24 hou To the Fune completely fi

Box 68760

Division of Vital Records, P.O.

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Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

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25. Was case referred to medical exeminer?
1 ☑ Yes 2 ☐ No 27. Menger of Deeth 5 Pending investigation 1 Naturel

2 Accident

3 ☐ Suicide

28e. Dete of Injury (Month, Dey Year) 28b. Time of

28c. Injury et Work? 1 Tyes 2 □ No

28d. Describa how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated.

6 Could not be determined

28f. Locetion (Street end Number or Rural Route Number, City or Town, Stete)

29b. Signature and titletof certifier

KNESHIM

29c. License number D3,494 29d. Date signed (Month, Dey, Year) 1199

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. K nesh lwo Death Medical contr 611

31. Dete filed (Month, Day, Year) 3 1999 MAY

south charles St Balhhar MD 21236 82. Registrer's Signeture

		State of Maryland / Department	rtificate of Death	Reg.	7200		
Physic /Medi		1. Decadent's Nama (First, Middla, Last) + 10 n C e S D + 70 n C	2 Sh,	april.	Day Year 9.03 PM		
Funeral Director	ner	4a Facility Nama (If no Institution, give street and number) 5. Social Security Number 6. Sax 1 M 205 F 7. Age (In yrs. last birthday) Yrs.	# Under 1 Year If Under 24 Hrs Months Days Hours Min		4c. County of Death 9. Birthplaca (Stata or Foreign Country) MD		
tand tand		Usuel Rasidance of Dacedant 10a. Stete 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits		
the Marylar 28a-f show	ctor	MD N/A BAUTIN	TORE		Yas 2 No		
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5-0020 72 hours after death with the Maryland neturel; or items 23s or 28s-f show	by Funeral Director	1 Nevar Marriad 2 Married 1 Yas 2 No	Was Decedent of Hispanic Origin? (S if Yas, specify Cuban, Mexican, Puar 1 Yas 2000 Specify:	Specify Yes or No- to Rican, atc.)	U.S.a. 14. Race - American Indian, Black, Whita, atc. Specify: Z.i.o.		
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mantal Hyghene. T Is marked other than "natural", or traumatic event, the Marical Exam	d pa	3 Widowed 4 Divorced Yeer or Detes:	dent's Usual Occupation	161	. Kind of Business/Industry		
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Maryladd 2 should the and Merker T Is market trsumetic	Ě	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailin	ng Addrass (Street and Number or R				
		20a. Mathod of Disposition 20b. Place of Disposements and Place of Di	natory or other place)	Date 200	MD 21090 Location - City or Town, Stata		
Baltimore, permit. Pages 1 ar Department of Heal Important: If Item 2 any Injury or other once.		21. Signatur of unital Service Licensee 22	Betts Funeral HOme de Balto, M d21213				
C8760, ficate be assected ficate be assected by physician and as the bunst-transit	edicai Examiner	23a. Part1. Enter tha diseesa, or complications that caused tha death. Do not ent shock, or heert feilura. List only ona cause on each line. Immediata Cause (Final disease or condition rasulting in death) Dua to (or as a consection of the cause) Sequentially list conditions, it any, leading to immediata causa. Entar Undarlying Cause (Disease or injury that initiated evants resulting in death) Last Dua to (or as a consection of the cause of the cause) Dua to (or as a consection of the cause) Dua to (or as a consection of the cause) Dua to (or as a consection of the cause)	CARDIAL INFO	unction	Approximata Intarval Between Onset and Death		
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0 4 5 6		27. Menner of Death 1 Natural 5 Pending 2 Accident Injury (Month, Day Year) 28b. Tima of Injury		28d. Describe how i			
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To the within To the comple	Me	29b. Signature and vale of capifler MD	29c. License number D1 7/3/		Deta signed (Month, Day, Year) L - 28-99		
(7)		30. Name and addrass of person who complated causa of death (Item 23a) (Type, G. U. STURNT, 1000 EAUER ST	BMTO MD S	11202			
Sta		31. Dete filed (Month, Day, Year) 32. Registrer's Signetura	4 1-11				

College (1-4or 5+) NA

15. Decedent's Education (Specify only highest grade completed)

Elemantery/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informent's Neme/Ralationship (Type, Print)

Carolyn Floyd - Wife

4 ☐ Donetion 5 ☐ Other (Specify)

21. Signeture of Funeral Service Licenses

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete

9th grade

HerCules Floyd

20e. Method of Disposition

Baltimore, Maryland 21215-0020 Department of Health and Important: If Health and Important: If Health 27 is man any Injury or collection.

filed within 7 i Hygiene. other than "n

12 should be fi and Mental H is marked of

Be

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Physician /Medical Examiner

physician and the burial-transit certificata be executed Box 68760 for use as 980 P.0. signed t Records, page 2 s of Vital this After Division or Attending To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun

Immediate Ceuse (Finet disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate causa. Enter Underlying Cause (Diseese or Injury that initieted evants resulting In death) Lest

Examiner Physician/Medical þ Completed Be 25. Was cese raferred to medicat exeminer? 2 27 Menner of Deeth Certification: 1 Matural 2 Accident 3 ☐ Suicide

23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one cause on each line. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Minnie

Road

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Heavy Equipment Operator

22. Name and Address of Fecility

4226 Pimilco

20b. Plece of Disposition (Name of cemetery, crematory or other place)

King Memorial Park

F/H West Wabash Avenue Baltimore, Md 21215 Approximete Intervel Between Onset and Death

5-1-99

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code)

18. Mother's Nema (First, Middla, Maiden Surname)

Due to (or es e consequence of) Due to (or es e consequence of): Due to (or es a consequence of):

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death?

1 | Yee 2 | No 3 | Probably 4 Nonknown 24a. Wes en autopsy

24b. Were eutopsy findings available prior to completion of cause of death? performed'

28, 1999

1 Yes 2 No

APRIL

1 ☐ Yes 2 ☐ No

3. Time of Death

1725 PM

S.C.

16b. Kind of Business/Industry

Baltimore, Md 21215

Baltimore City

20c. Location - City or Town, State

Randallstown, Md

1 Ves 2 No

26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1⊠ Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient X DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at

5 Pending Investigation 1 Yes 2 No

6 Could not be datamined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At homa, ferm, street, factory, office building, atc. (Specify) 4 Homicida

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner steted. (Check only one) 29b. Signature end titla of certified 29c. License number 29d. Date signed (Month, Day, Year)

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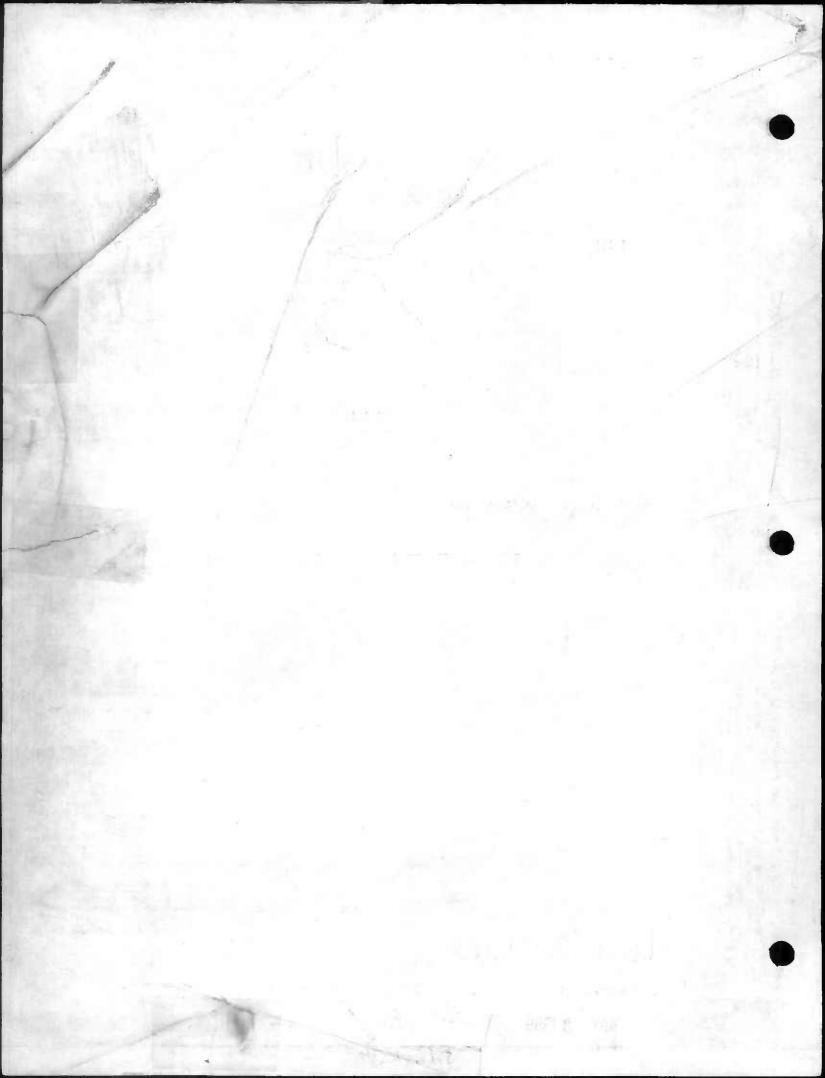
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UALIBRIMA (MV) 111 Penn Street, Baltimore, Maryland 21201 KOYEW 31. Date filed (Month, Day, Year)

State Registrar

Medical

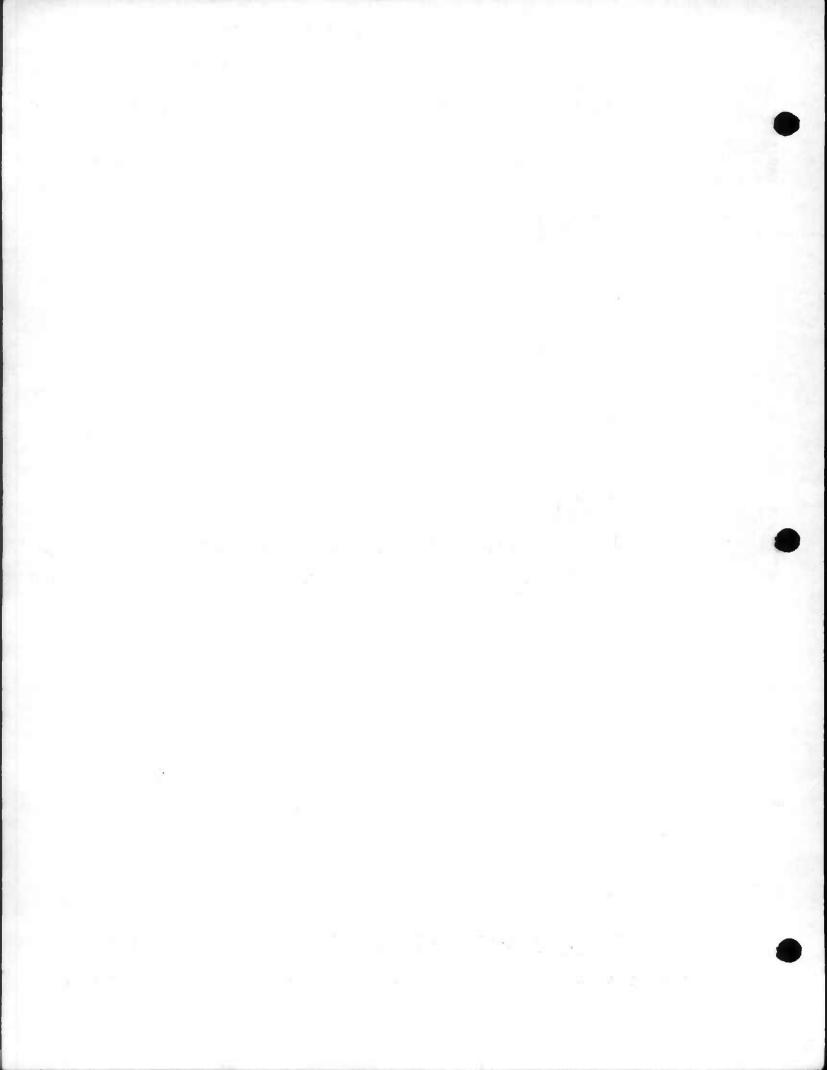




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State of Maryland / Department of Health and Mental Hygiene 99 4232

						Certific	ate of	Death		Reg. No.		TLUL					
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				anor				Millersu	110	Hnn	e Anu	indel					
Fune Direct			5. Sociel Security Number 6. S 212-22-8338	Sex 7. A	ige (In yrs.	lest birthday) If Ur Mont	der 1 Yea hs Days			rth ey, Year) 23-08	9. Birthp Cour	piece (State or Foreig otry) Uq					
pu *		-	Usual Residence of Decedent 10a. Stete 10b. County		10c Cit	y, Town or Location						0d. Inside City Limits					
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the 288		runeral Director	MA Ba 10e. Street end Number	170	1 1 0		Zip Code			10g. Citizen o	f What Cour						
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death		era	11. Marital Stetus	12. Wes Deceden	t Ever in U.	,S. 13. Wes De		Hispanic Origin? (S ben, Mexican, Puer	Specify Yes or No	D- 14. R	ace - Americ	can Indian,					
ire, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 21s a marked other than "natural", or items 23e or 28e-f show then traumatic event. Its Medical Extrans.		2	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces 1 Yes 2 19 If Yes, Give Yeer or Detes	(No		s 2 DNo		to Rican, etc.)	Spec	leck, White, eify: Bla	etc.					
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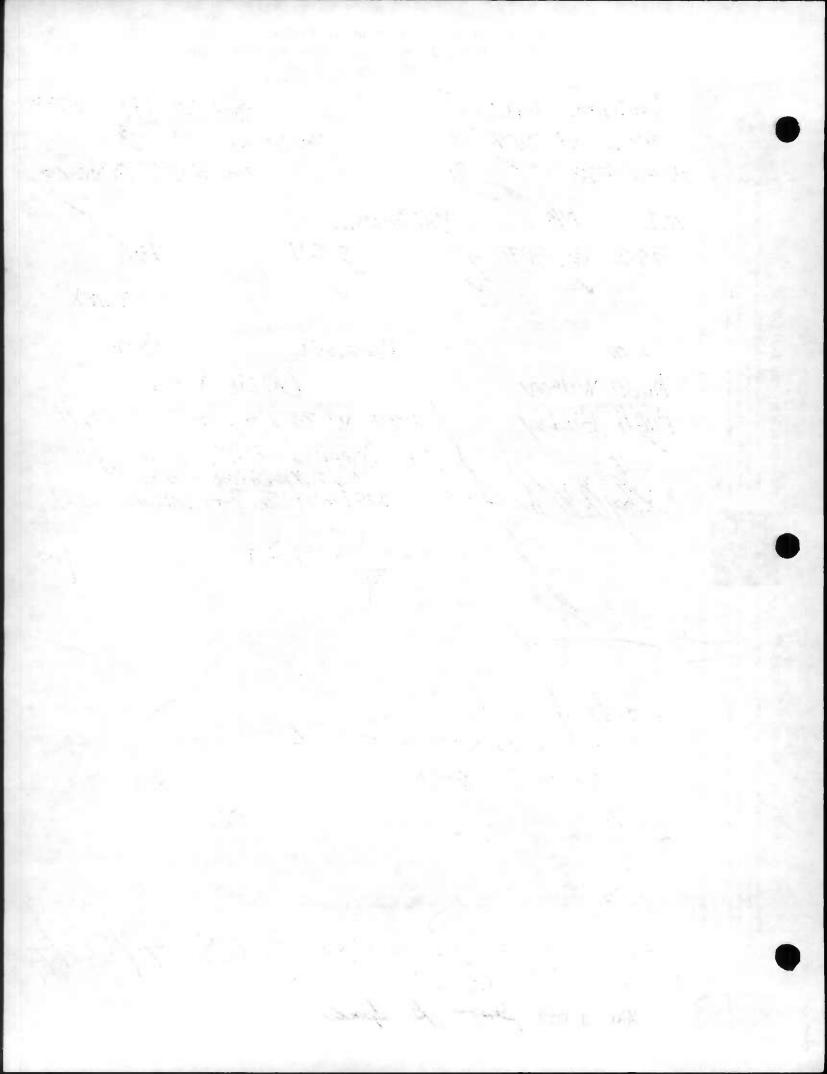
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Data of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:55 PM 4c. County of Death /Medical 4a Facility Nama (If not Institution, giva straat and number) 4b. City, Town, or Location of Death **Examiner** BALTIMO If Under 24 Hrs. 次万 8. Date of on /State or Foreign 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Bi **Funeral** Min. Months Days Hours 354-18-946 Usual Residence of Decede 1 M 2 M Yrs. Director the Marylend 10c. City, Town or Location r 28a-f show 10a State 10b. County 10d. Inside City Limits 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ŏ traumetic event, the Madical Examiner must be items 23a Funerai 12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours efter and Mentel Hygiene.
Is marked other than "naturel", or its 2 Married 1 Never Married 1□Yes 2□No Baltimore, Maryland 21215-0020 Specify λq 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

HOUSID-WIFE 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) condary (0-12) College (1-4or 5+) 17. Father's Nama (First, Middla, Lest) 18 Mother's Name (First Middle Maiden Surneme Be 2 permit. Pages 1 and 2 an Department of Health and Important: If them 27 is ma any injury or 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Info 20b. Place of Disposition (Nama of 2 Cremation 3 DRemoval from State Other (Specify) 4 Donation bisease or complications that caused the death. Do not after the mode feiture. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) acinom G Examiner Due to (or as a consequi-Examiner physician end the buriel-trensit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequenca of): Box 68760. Physician/Medicai Dua to (or as a consequence of): 80 957 ò 23b. Did tobacco use contribute to the cause of death? ed by the e Part II. Other algorithms conditions contributing to death but not resulting in the underlying cause givan in Part I. Division of Vital Records, P.O. 20 No 3 Probably 4 Unknown signed by 1 Yes ρ should be 24b. Wera autopsy findings availabla prior to completion of cause of death? 24a. Was an autopsy performed? Completed this certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residenca 6 Other (Specify) Hospital: 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Inpatient 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending 1 Yes Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homlcide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. Medical completely (Check only one) ination end/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) medical Examiner: On the basis of exc and manner stated 29b. Signature and title of certifier Licansa numbar 29d. Data signed (Month, Day, Year) 30. Name and addrass of person who so ed cause of death (Its n 23a) 31. Date filed (Month, Day, Year) 32 Registrar's Signeture

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yee **Physician** 27, 1999 4c. County of Deeth GLENN RIDENBAUGH GRAY APRIL 1999 2:00 PM /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) **Examiner** Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) April 12, Birthplece (State or Foreign Country) **Funeral** Months Deys 1 M 2□ F Yrs. 220-20-2493 72 1927 Maryland Director Usual Residence of Decedent death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside Cltv Limits permit. Pages 1 and 2 should be filed within 72 hours eiter death with the Maryfar Department of Health and Mental Hygione. Important: If them 27 is marked other than "naturel; or Herra 23 a or 28e-f show any injury or other traumatic event, its Medical Examples. In mart be notified as 1 Yes 2 No MD. Director Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 Warren Rd. 21030 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status Bleck, White, etc. 1X X es 2 ☐ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 1 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: P White WWII 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) +4 Systems Analyst Environ. Engineering 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Clifton Webb Gray, Lillian Ridenbaugh 2 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patty Gray/ Wife 507 Warren Rd. Cockeysville, MD. 21030 20b. Place of Disposition (Name of cametery, cremetory or other place) Dete 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removal from Stete Dulaney Valley Mem.Gd4-30-99 Timonium, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
Ruck Towson Fu
1050 York Rd. 21. Signature of Funeral Service Lio Funeral Home, . Towson, MD. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel LIVER FAILURE 3 MONTHS diseese or condition resulting in death) Examiner Due to (or as e consequence of): Examiner attending physicien and for use as the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequenca of): P.O. Box 68760. Physician/Medical Due to (or es a consequence of) 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by t should be detach 1 Yss 2 No 3 Probably Wunknown Records, py 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy Completed has 2 No 1 ☐ Yes 2 No Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: or Attanding Patter death. After 1 Neturel
2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in 29a. Certifier (Check only one) Medical Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner as steted. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 26954

State Registrar PEMY CHHIM,

31. Date filed (Month, Dey, Year)

OSLER DRIVE.

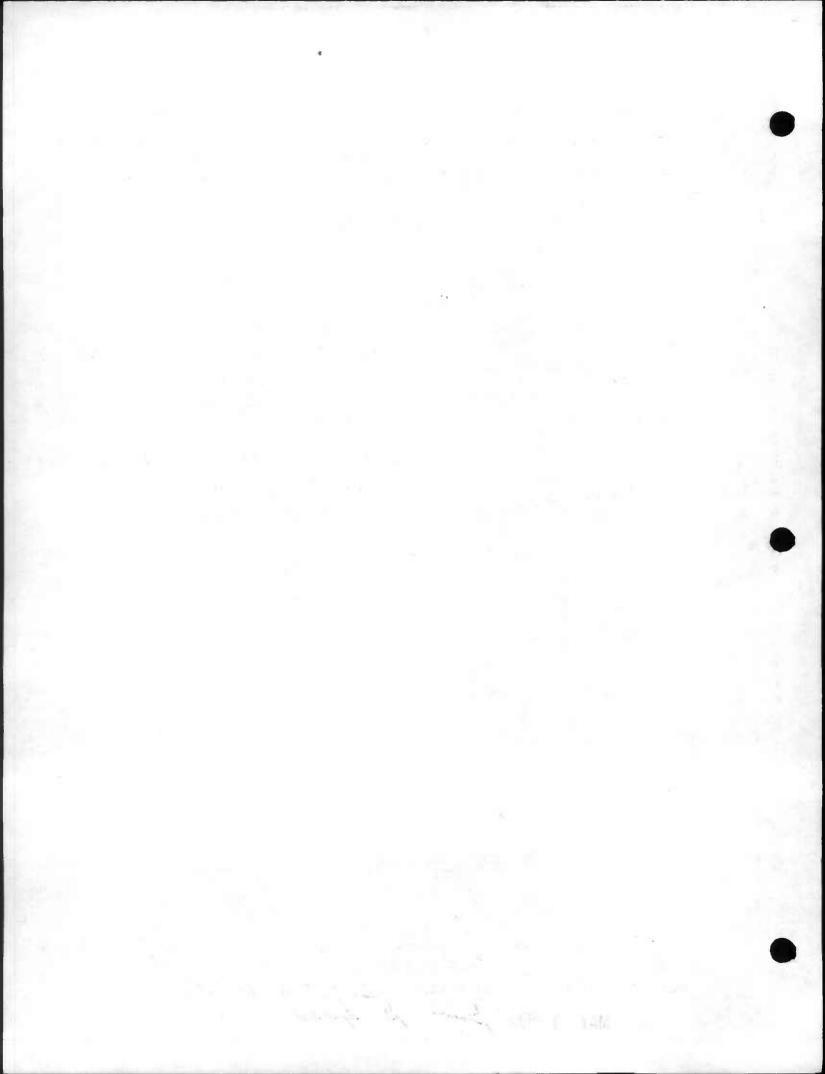
TOWSON, MD 21204

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

M. D.

7601

32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** 29, ROSE 1999 **GEIWITZ** April 10:00 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Baltimore If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar 8. Data of Birth (Month, Day, Year) Mar. 13, 1 Birthplace (Stata or Foraign Country) Funeral Months Days 1□ M 2Å F Hours 212-30-0309 92 Director Md. **Usual Rasidence of Decedent** the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Directo 289-1 Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? £, 8 must be 615 Chestnut Ave. 21204 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14 Race - American Indian 11. Marital Status Black, Whita, atc. filed within 72 hours after 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Dates: 1 Never Married 2 Married il Hygiene. other than "natural", or it rent, the Medical Examin Saltimore, Maryland 21215-0020 1 Tyas 2₹ No Specify: à 3 Widowed 4 Divorced White Completed Decedent's Usual Occupation
 (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Solicitor Telephone Company 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) 89 Pages 1 and 2 should be tent of Health and Mental Verdal Frank Barbara Caplan 19a, Informant's Name/Ralationship (Type, Print) PICKETSGILI 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Item 27 It other tra Retirement Ctr./care giver 615 Chestnut Ave. Towson, Md. 21204 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata E ö Department of Important: If any injury or 4 ☐ Donation 5 ☐ Othar (Specify) 5/3/99 Parkville, Md. Parkwood Cemetery 21. Signature of Funeral Service Licensee 22-Name and Addrass of Faeility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximata** Intarval Batween Onsat and Daath **Physician** /Medical Immediata Causa (Final Cardiac Arrythmeia disaasa or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner Fracture Rt. Hip buriei-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequenca of) and or Attending Physician: The law requires that the death certificate be exec Box 68760, Arteriosclerotic Cardio Vascular Disease Physician/Medical the Dua to (or as a consequence of): phy use as t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. be detached 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Metastatic Cancer of Breast Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? has page 2 1 ☐ Yas 2 1 No 1 ☐ Yas 2 ☐ No certificate Division of Vitai director, Be 25. Was casa rafarred to medical 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Medical Certification: To 11 Yas 2 □ No this funeral 27, Manner of Death 28b. Tima of 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending invastigation 1 Natural 1 Yes 2 No To the Hospital or Attendion within 24 hours effer death. To the Funeral Director: A 4/29/99 2 Accident 10:00 A Fell in own room 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be detarmined 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) filled in by 4 Homicide 6905 Charles St. Towson, Md. Gilchrist Center GBMC 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. (Check only one) 29b. Signature and fittle of partities 29d. Data signed (Month, Day, Year) 20c Licanse number 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) NAR 3. DONNE 31. Data filed (Month, Day, Year) 32. Registra's Signatura State 3 1999 MAY

DHMH 16 Rev 6/95

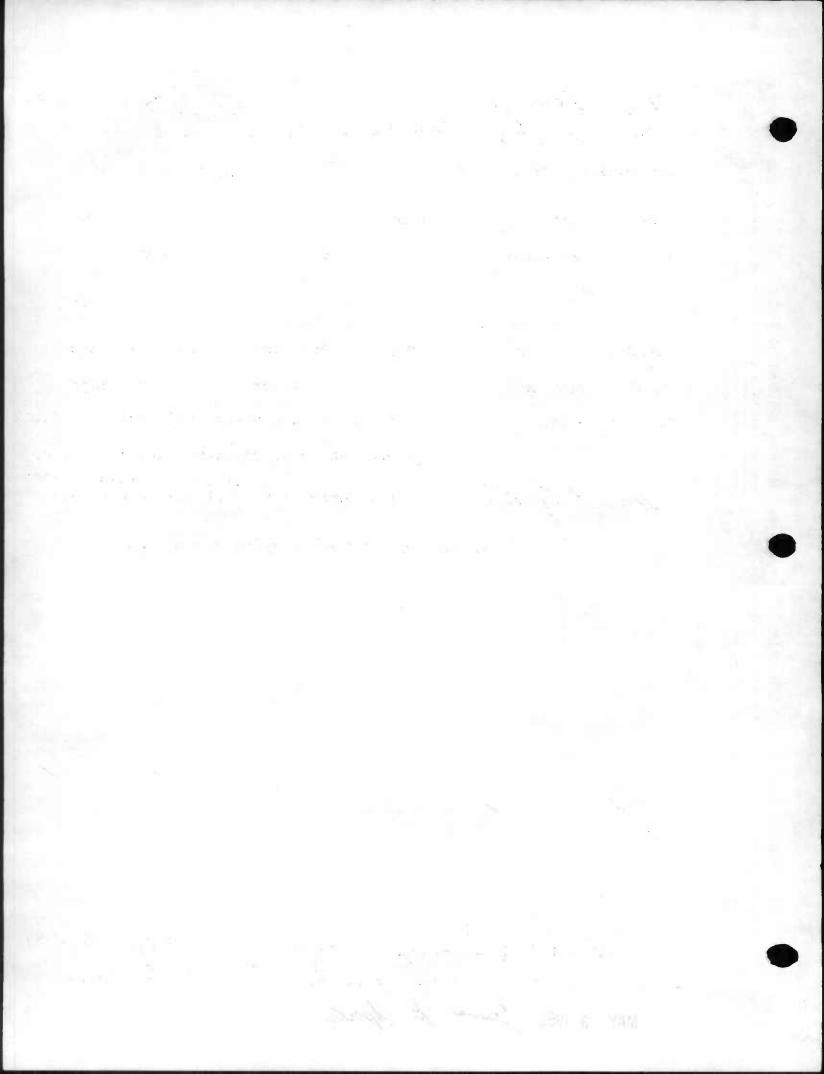
Registrar

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FUS Ame	nded Item#19a perfiff G 1. Decedent's Name (First, Middle, L		Cel	tificate of	Dealli	2. Dete of Dea	Reg. No.		3. Time of Death		
Physiciar /Medica	John James H						27, Dey 1999		16:41 PM		
Examine	4a Facility Name (If not institution, g NORTH ARUNDAL I				4b. City, Town, or L Glen Bur			of Deeth ARUN	DAL		
Funeral Director	212-52-4056	Sex 1 M 2 F 7. Age (I	n yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, De Aug. 9	1949	9. Birthpl Count Mary	ace (Stete or Foreign (n) Land		
pu & m	Usuat Residence of Decedent 10a. State 10b. County	10	0c. City, Town or Lo	cation				10	Od. Inside City Limits		
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fier deeth with the Ma Freme 23e or 26e-1 e liner must be notified	10e. Street and Number		10f. Zip				10g. Citizen of \				
23a	102 Chalmers Ave	nue	win II C 12 1	2106	1 lispanic Origin? (Sp	posity Van ar No	United	Stat.			
020	3 ☐ Widowed 4 20 Divorced	Armed Forces?		Yes, specify Cubi	Rican, etc.)	Blee	White, e	etc.			
ore, Maryland 21215-0020 ss 1 and 2 should be filed within 72 hours of of Heelth and Mental Hydens. Hem 27 is marked other than "natural", or other treumatic event, the Medical Event	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5+)	(Give		pation during most of work d)	ing	16b. Kind of B				
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id be fill be		•			18. Mother's Nam Margare	t Willi		ne)			
and M	19a. Informant's Name/Relationship	(Type, Print)	19b. Meilir	g Address (Street	end Number or Rui	ral Route Numbe	er, City or Town,	Stete, Zip	Code)		
Fe, M Heelth Hem 27 I other tr	Margaret Horafus										
Pege ment of any or	20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Special Control of Control	☐Removel from State	Metro Cre	b. Place of Disposition (Name of cemetery, cremetory or other place) etro Crematory, Inc. Dete 20c. Location · City or Town, State 5/1/1999 Catonsville, MD							
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To the company of the	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	d (Month, I	Dey, Year)		
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	HARYANTO A	completed cause of death	1 111		eet, Balt	imore,	Marylan	d 212	01		
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's	Signeture &	. Soon	les						

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	4a Facility Name	(If not institution, giv	e street and num	mber) 1	redical	Center	4b	0 11.	r Location of Das		unty of Death	
	5. Social Security 215-40)-5825	Sex □ M 2□F	7. Age (In yrs. 65	last birthday) Yrs.	If Undar 1 Y	aar ays	If Under 24 Hr Hours Mir	n. (Month, L	orth Day, Year) 07-39	Cou	place (State or Foreign intry) AD
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Medical Certification: To Be Completed by Physician/Medical Examiner	disease or conditing in death resulting in death fany, leading to cause. Enter Unc Ceuse (Disease of that initiated avan resulting in death fant fant fant fant fant fant fant fant	erred to medical No eth 5 Panding invastigatio 6 Could not be determined	d	Dua to (compatible to the path but not respect to the path	or as a consector as	quence of): quenc	Other Injury Office	26. Place of D r: 4 Nursing at ? es 2 No a, date end pla inion, deeth oc number	23b. Di 1[24a. Wa pe 1[Homa 5 □ Re 28d. Describ 28f. Location City or 7	d tobacco us Yea 2 Yea 2 as an autopsy rformad? Yas 2 Yone) Isidence 6 e how injury of a (Street and frown, State) na cause(s) ar a, data and pl 29d. Data s	occurred Other (Special Mumber or Ruind manner es aca, and dua signed (Month)	to the cause of death? obably 4 Unknow Vera autopsy findings valiable prior to completion of causa of death? Yas 2 No city) ral Route Number, steted. to the cause(s) n, Day, Year) 2 9 9 9 9 9 9



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	State of Maryland / Department of Health and Mental Hygiene	1.5	6	3	Ü
	Certificate of Death				

Physician /Medical Examiner

INTERSECTION OF LEXINGTON & PULASKI STRS.

2. Dete of Death Month APRIL

3. Time of Deeth

4a Facility Name (If not institution, give street end number)

4b. City, Town, or Location of Death

1900 PM

Funeral Director

r than "natural", or flome 23s or 28s-f show the Medical Exempler must be notified at

filed within 72 hours after Hygiene. Wher then "neturel", or he

permit. Pages 1 and 2 should be filed wh Department of Health and Mental Hygiana Important: if Item 27 is marked other tha any injury or other traumatic event, that

Physician /Medical

Examiner

physician and s the burial-transit

cata has been sig , page 2 should b

director,

Sign of funaral

After

o Funeral Director: Att

To the Hosp within 24 hos To the Fune completely fi

The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Attanding Physician:

6

Hospital

Examiner

Physician/Medical

à

Completed

8

edical Certification: To

Baltimore, Maryland 21215-0020

Director

Funeral

P

Completed

8

99-2451-510

5. Social Security Number 7. Age (In yrs. last birthday) BALTIMORE CITY If Under 24 Hrs.

13-86-Usual Residence of Decedent

309 1X M 2□ F Yrs. If Under 1 Year Days Months Hours

Bighplace (State or Foreign Pountry) Vary and

Year

10a. State

10b. County 10c. City, Town or Location

Jackson

timore

10d. Inside City Limits 1 X Yes 2 □ No

10g. Citizen of What Country?

29, 1999

4c. County of Dont

Dev

Mary land 10e. Street and Number

06

Ld N Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indien Bleck, White, etc.

11. Marital Status

1 Never Merried 25 Married 3 ☐ Widowed 4 ☐ Divorced

1. Decedent's Neme (First, Middle, Last)

12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No Year or Detes

1 ☐ Yes 2 No Specify:

Applicates: Hmerican 16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+)

ac

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

10

bore

19b. Mailing Address (Street and Numb

10f. Zip Code

18. Mother's Name (First Middle Maiden Sumeme)

nes

Zip Code)

17. Father's Neme (First, Middle, Last)

anie a 19a. Informant's Name/Relationship (Type: Print)

of Funeral Service License

20b. Plece of Disposition (Neme of cemejery, cremetary, cremetary, cremetary, cremetary, or other

20c. Location or Town, Stete

20a. Method of Disposition

1 X Burial 2 Cremetion 3 Removal from State 4 Donation 5 □ Other (Specify)

Viem 22. Name and Address of Fecility 30

2

Garden er Ave North

homasine

21. Signatu

ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, it is only one cause on each line.

21216 Approximete Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death)

e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or es e consequence of):

Due to (or as a consequence of):

23b. Did tobacco use contribute to the cause of death?

1 Yaa 2 No 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

24a. Wes en autopsy performed?

24b. Were eutopsy findings eveilable prior to completion of cause of death?

1 Yes

Yes 2□ No

25. Wes case referred to medical examiner? Yes 2□ No

5 Pending

6 Could not be determined

28a. Date of Injury (Month, Day Year) 7/89 investigation 412

Hospitel:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 18434RM

28c. Injury et Work? 1 ☐ Yes

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 NOther (Specify) AT SCENE 28d. Describe how injury output

vehil accide Location (Street and Number or Aural Route Number, City or Town, State) Lexing for + Puleshing Theat Bultimore Many Carel Baltimore Mans

29a. Certifier (Check only one) Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 and 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and menner es stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) and manner stated.

27. Manner of Death

1 Natural

2 Accident
3 Suicide

4 Homicide

29b. Signature and title of certifier

28e.

29c. License number OCME

29d. Date signed (Month, Day, Year) APRIL 30, 1999

- M. no 30. Name and address of person who completed caused death (Item 23a) (Type, Print)

3 1999

THEODINE MIKING 31. Date filed (Month, Day, Year)

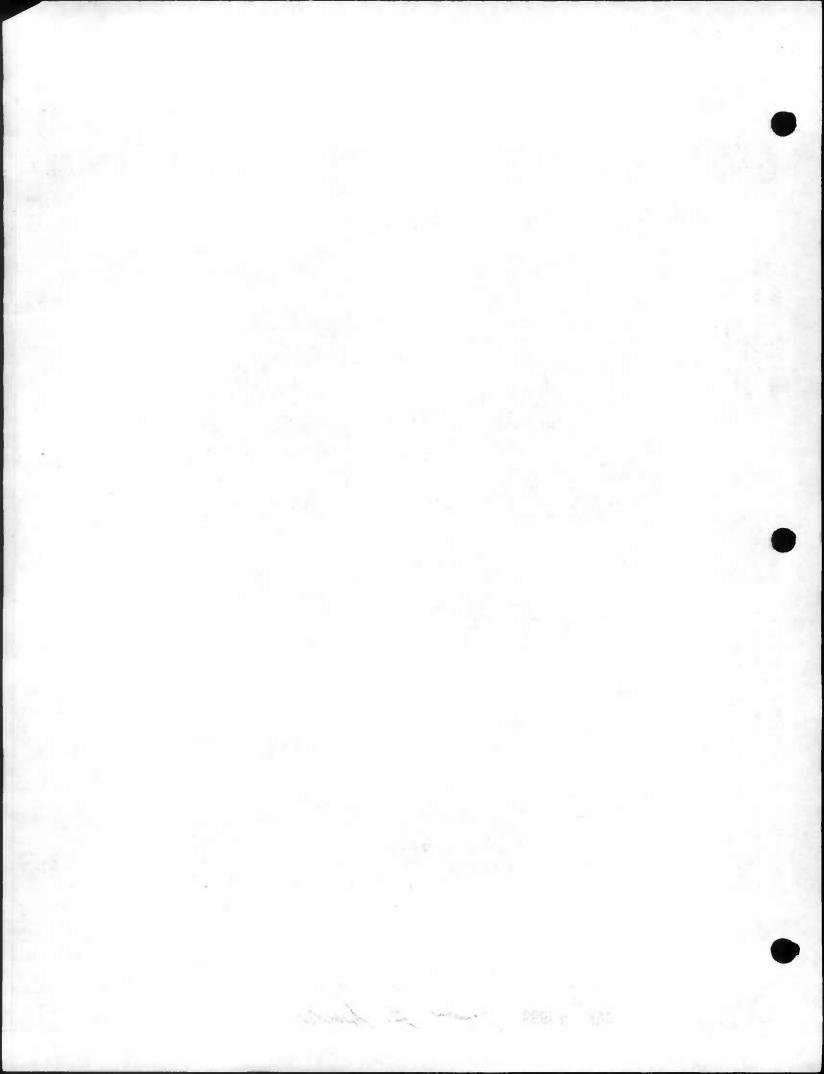
111 Penn Street, Baltimore, Maryland 21201

32. Registrer's Signeture

State Registrar

DHMH 16 Rev 6/95

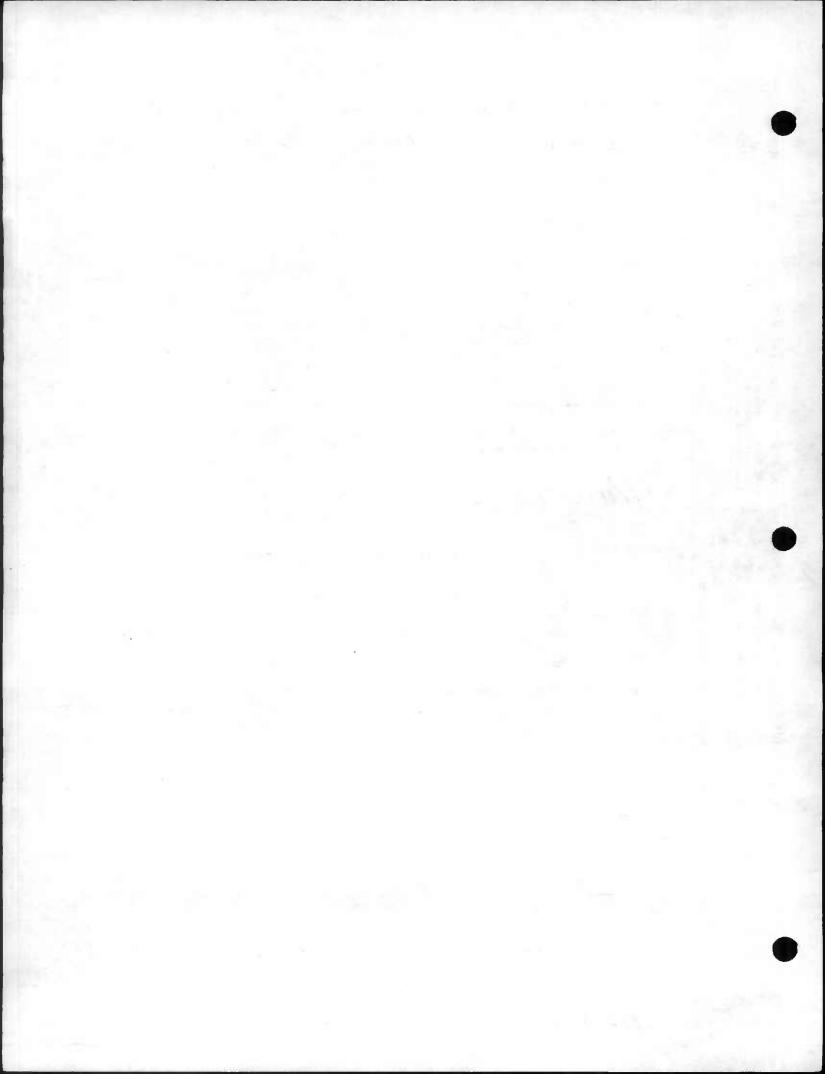
ORIGINAL



Piease Type or Print in Biack Indelibie ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Year **Physician** tha 3 er Mae M 1999 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) Examiner Hospita 140 Hopkins If Under 1 Year | If Under 24 Hrs. 9. Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days 1 M 2 TF 67 YES 216-32-4905 Sept 15,1931 Director SC Usuel Residence of Decedent with the Manylend 10c. City, Town or Location 10a. Sfete 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1√2 Yes 2 No Director Balto MD N/A 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 1754 Darley Ave 21213 14. Race - American Indien, Black, White, etc. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status 72 hours after 1 ☐ Never Merried 2 ☑ Merried 1 Yes 2 No Saltimore, Maryland 21215-0020 1 Yes X No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working fife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ifiled within 7 I Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) City Schools 8th Short Order Cook permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If Itam 27 te marked other tany injury or other traumatic avent. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maiden Sumeme) Be Bertha Lightner Joe Jones 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, Md 21213
Date 20c. Location - City or Town, Stete 1754 Darley Ave Robert Jones Sr 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removel from Stete Baltimore Cem 5-4-99 Balto, Md 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Puneral Service Licensee 22. Name and Addrass of Fecility Betts Funeral Home 1129 N. Caroline St Balto, Md 21213 23a. Pert1. Enter the disease, or complications that daused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailura. List only ona cause on each lina. C Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final diseasa or condition resulting in death) /Medical Disease theine's **Examiner** Examiner Inotr physician end the burial-transit Sequentielly list conditions, if any, leeding to immediate causa. Entar Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. certificate be Physician/Medical Due to (or es e consequance of): as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably Worknown Records. by 24b. Wara autopsy findings eveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed peen certificate has page 1 Yes 25 No 1 ☐ Yes 2 No Division of Vital Physician: the funeral director. 25. Was case referred to medical 26. Place of Deeth (Check only one) Be 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) To After this 27. Menner of Death 28e. Date of Injury (Month, Dey Year) To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 28d. Describe how injury occurred 28c. Injury at Work? Certification: Maturel 2 Accident 5 Pending investigation 1 Yas 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier The Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29c. License number 29b. Signature end title of certifier D46676 MoliesM 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Belair Road Michaelle Holmes 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State Registrar 3 1999

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death 28 1216 PM Naomi Vera Jackson 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Hospital Ghen I Hunder 1 Year I Hunder 24 Hrs. Min. GLEN BURNIE Anne ARUNDEL ARUNDEL 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplaca (Stata or Foraign Country) 1 M 2 5 Months Days Hours 216-34-7839 64 Aug. 30, 1934 Md. Usual Rasidance of Dacedan 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits Anne Arundel Md. Hanover 1 Yas 2 XXIXIO 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 21076 USA 1529 Matthewtown Road 12. Was Decadant Evar in U,S. Armed Forcas? 1 ☐ Yas ② No If Yas, Giva Yaar or Detas: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 Never Married 2 Marriad 1 ☐ Yas 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highast grada completed) Anne Arundel County College (1-4or 5+) Elamantary/Secondary (0-12) Public Schools Teaching Assistant 18. Mothar's Nama (First, Middla, Maidan Sumeme) 17. Father's Nama (First, Middle, Last) Mildred Cook Arthur Montgomery 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Husband Christopher Jackson, Jr. 1529 Matthewtown Road Hanover, Md. 21076 20b. Place of Disposition (Nama of camatary, crametory or other pleca) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☑ Surial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Hanover, Md. May 3 St. Rest Cemetery 21. Signatura of Funeral Sarvice Licensee 22. Nama and Addrass of Facility Nutter Funeral Homes, Inc. erber 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiretory arrast, shock, or haart failura. List only one cause on each line. Approximata Intervel Between Onsat and Daath Septicemia 1 Welle Immediata Causa (Final disaasa or condition resulting in deeth) Due to (or as a consequence of): Chronic Reval Sequantially list conditions, if eny, leading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated events rasulting in daeth) Last Dua to (or as a consequence of): abehe Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use coptribute to the cause of death? Ruputured Diny Viculogy 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings eveilabla prior to completion of ceuse of death? 24a. Was an autopsy 1 Yas 2 No 1 Yes 2 No 25. Was casa rafarred to madicel 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No # Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of injury (Month, Dey Year) 27. Manner of Deeth 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1-ENatural 5 Panding 1 Yas 2 No invastigation 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28a. Place of injury - At homa, farm, straat, factory, offica building, atc. (Specify) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

Box 68760. o. Records, Division of Vital **Physician**

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

Hygiene.

12 should be fith hend Mental H

permit. Peges 1 end 2 Depertment of Health of Important: If Item 27 it any Injury or other tra

Physician

/Medical

Examiner

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24 hours

To the To the To the I

Hospital or Attending Physician:

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State Registrar

31. Deta filad (Month, Day), Yeer

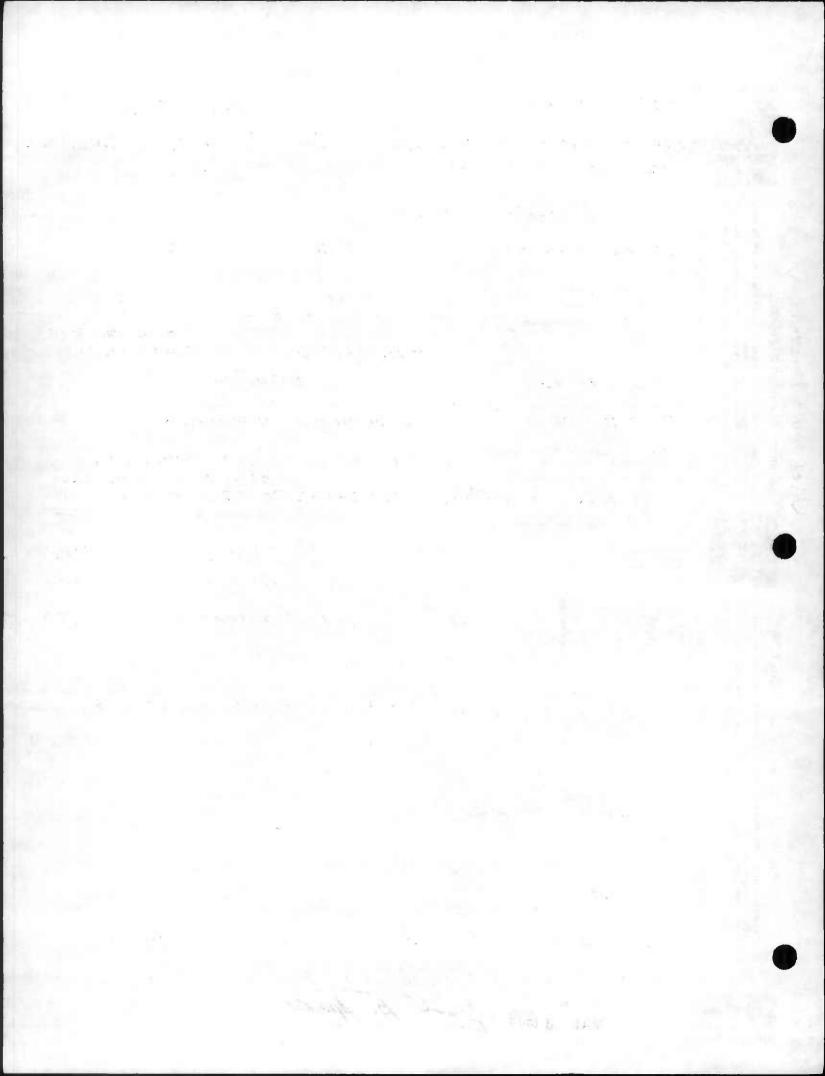
29b. Signeture end title of certifier

32. Registra s Signature

30. Nama and addrass of person who complated cause of death (Itam 230) (Type, Print)
DALJITS. SAWHNEY Suite 201 Crain Towers Glen Burnie 21061.

29c. Licensa number

29d. Data signed (Month, Day, Year)

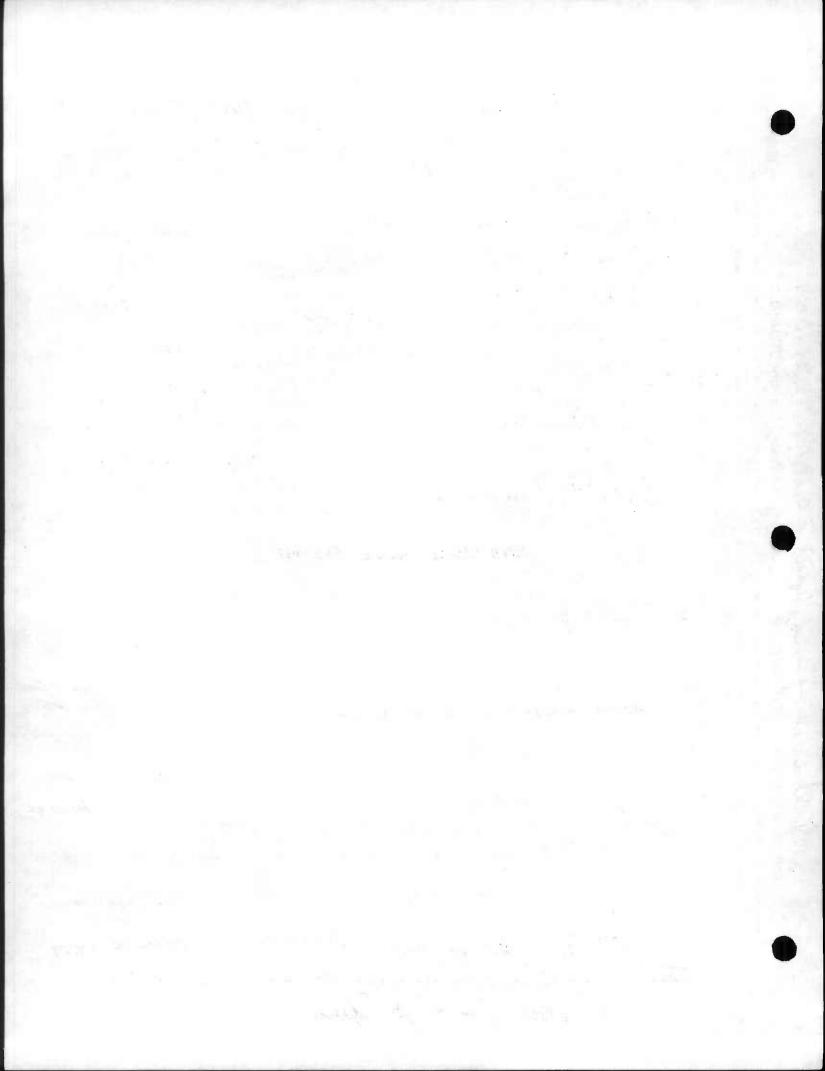


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** hanic 2:10 ones /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) Examiner 7. Age (Inlyrs. last birthday) ichie ph If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country), 6. Sex **Funeral** Months Hours 1 M 2 F 216-20-7320 Director Sept.3,1928 Ba Usual Rasidence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23s or 28s-f show traumstic avent, the Macical Examiner must be notified at 1 Yas 2 No Directo laryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 212 Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 M Yas 2 □ No IYYas, Giva 1) - 20 - 45 Yaar or Datas: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black Specify: p 3 Widowed 4 Divorced 11-22-48 Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Illed within 7 Hygiena. permit. Pagas 1 and 2 should be liled withir Department of Haalth and Mental Hygiens. Important: If Itam 27 is merked other than any Injury or other traumatic avant Elamentary/Secondary (0-12) College (1-4or 5+) maintance ian 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Smith OlPuia Inomas Jones 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Rendellstown MD.21133
20c. Location - City or Town, Stata Sharon tin-Dayshter rele 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Date may 1 Burial 2 Cramation 3 Ramoval from Stata wings Mills Maryland 4 ☐ Donation 5 ☐ Othar (Specify) zarrison Forest 21. Signature of Funeral Service Disens 22. Nama and Address of Facility Douglass Funeral Service 1701 McCulloh Street Baltimore MD. 21217 da 23a. Part1. Enfar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line. Approximata Interval Batween Onset and Death Physician Immediata Causa (Final disaasa or condition resulting in death) /Medical END STAGE DISEBSE RENAL Examiner Dua to (or as a consequence of): Examine iclan and burial-transit Sequentially list conditions, if any, laading to immediata cause. Entar Undartying . Cause (Disaase or injury that initiated evants rasulting in death) Last . Due to (or as a consequence of): physiclan a Physician/Medical Due to (or as a consequence of): Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ADENO CARCINOMA م OF THE LIVER by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 Yas 2 No Vital 25. Was case refarred to medical axaminar? 80 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 NOther (Specify) HOSPICE 1 Yas 2 No 2 ō 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Aftar t Division Attending 5 Panding invastigation To the Hospital or Atlandir within 24 hours after death, To the Funeral Director: Al 1 Yes 2 No 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier complataly (Check only 29c. License number 29b Signature and tit 29d. Data signed (Month, Day, Year) D 06933 APRIL 30 Teobor ma completed cause of death (Item 23a) (Type, Print)

- 19LON MO 101 WREAD ST. BALTIMOLE MD 21201 address of per MACSIBBON MO 31. Data filed (Month, Day, Yar) 32. Registrar's Signature State MAY Registrar **DHMH 16 Rev 6/95**

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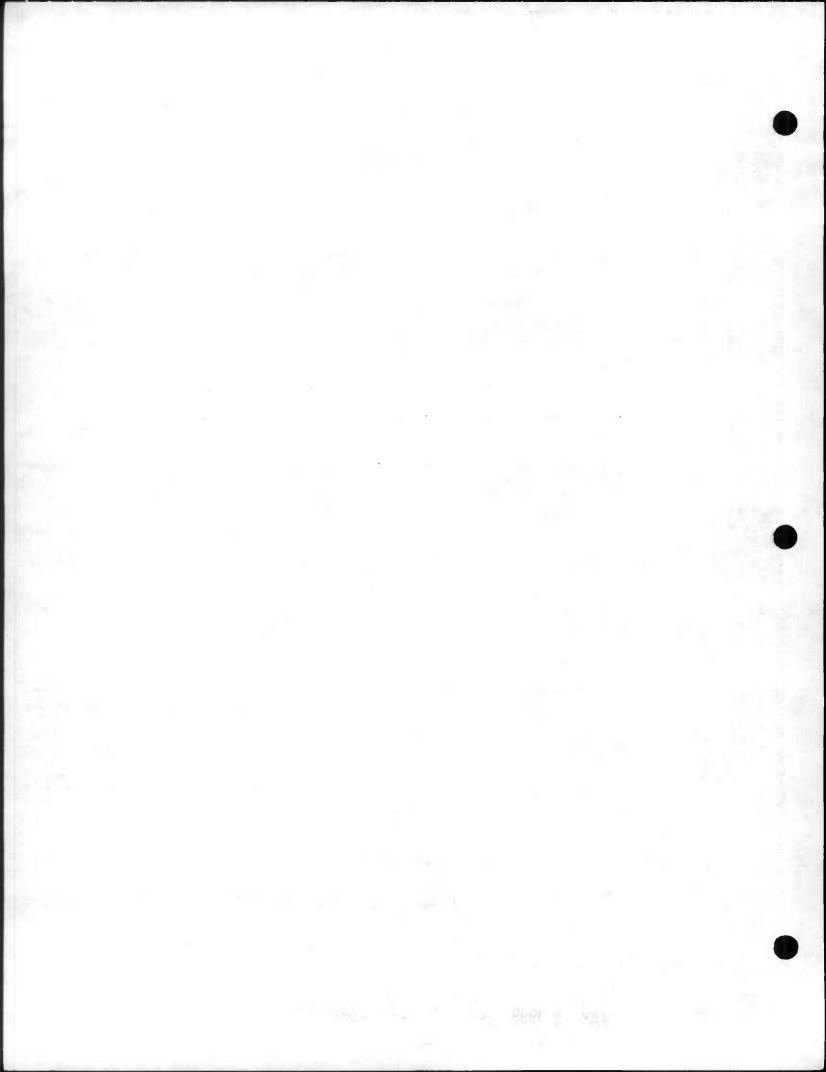


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Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey **Physician** 1999 MARIAN G. KINNAIRD April 29, 2:50 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Manor Care Towson Towson Baltimore If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Year) Mar. 15, 1 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 BF Director 147-22-9729 Ohio Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits "netural", or items 23s or 28s-f show 1 ☐ Yes 2 NO No Baltimore Director Md. Towson 10e. Street and Number 10a. Citizan of What Country? 10f. Zip Code With 509 E. Joppa Rd. Towson Baltimore Funeral filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 11. Marital Status 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 [™] Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Book Shop Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill ment of Health and Mentel Hant: If Item 27 is marked other yor other treumatic even Be Levi Gosnell Minnie Terrill 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Peggy Sargent/dtr. in law 7136 Lakeside Dr. Indianapolis, Id. 46278 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Prospect Hill Cemetery 5/4/99 Flemington, N.J. 22. Name and Address of Fecility
Ruck Towson Funeral Home, Inc. eture of Funeral Senace Lidera 1050 York Rd. Towson, Md. 21204 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiratory errest, shock, or heart failure. List only one cause on aech line. Approximate Interval Between Onsat end Death Physician Immediete Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner The lew requires that the death certificats be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician s the burie Physician/Medical Due to (or es a consequence of) US0 05 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably 4€ Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of daeth? Completed 24a. Was an autopsy performed? has page 2 1 Yes 2/2 No certificate 1 ☐ Yes 2 No Division of Vital or Attending Physicien: director Be 25. Was case refarred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No thia funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural ster death. 1 Tes 2 No 2 Accident 28f. Location (Street and Number or Rurel Routa Number, City or Town, State) To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by the 6 Could not be 3 ☐ Suicide 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Descripting Physician: To the best clamy provinge, death occurred at the tima, data and place, and due to the ceuse(s) and manner es stated.

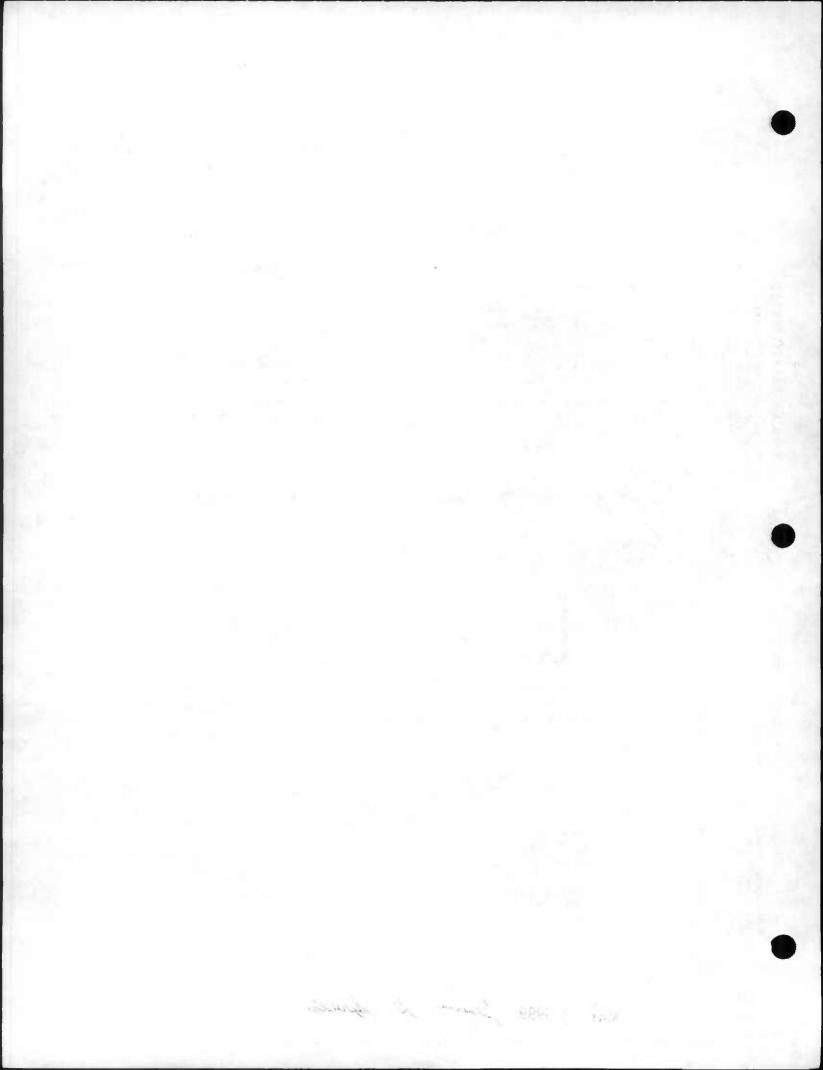
The dical Example: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, date and place, and due to the candination and manner stated. 29a. Certifie Medical (Check only one) Vor investigation, in my opinion, death occurred at tha tima, date and pleca, and due to the causa(s) 29b. Signature an 29d. Date signed (Month, Dey, Year) 29c. License number 0 person who completed sause of death (Item 23a) (Type, Print) Akkad, Ayman F. M.D. 7600 Osler Dr. Towson, 21204 Md. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 4 2 4 3

	1. Decedent's N	ama (First, Middle,	. Last)			icate of		2. Dete of D		.,	3. Time o	Death
Physician /Medical	John		Kotrla	a				M a y	1 ^{Oay} 1	gg'9	4:15	AM
Examiner			giva street and number asant Ave				6b. City, Town, 6 Baltin	or Location of Dea		of Death		
Funeral Director	5. Social Security 213-30-3	3097	6. Sex 1 M 2 □ F	Age (In yrs. last 66		Under 1 Year onths Days	If Under 24 H Hours M	8. Date of B lin. (Month, D 10-2-	irth 1932	9. Birthy Balti	place (Stete htry) more, M	or Foreign arylai
pue &	Usual Residence	of Decedant		10c. City, To	own or Locatio	on				1	10d. Inside C	ity Limits
Many tor	MD	n/a		Ba	altimor	ce						2 No
itter death with the Marylend r tenna 23a or 28a-f show ricer must be notified at Funeral Director	10e. Street and f 3724 M		ant Avenue		1	01. Zip Code 21	224		10g. Citizen of What Country? USA			
		1 ☐ Never Married 2 Narried 1 ☐ Yes 2 No		Decedent of H s, specify Cube Yes 2 No	Decedent of Hispanic Origin? (Specify Yes or No., specify Cuban, Mexican, Puerto Rican, etc.) Tes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Mohala Hygiene. Important: If tem 27 is marked other than "hetural", c any Injury or other treumatic event, the Health and Engles. To Be Completed by		15. Decedent's pecify only highest econdary (0-12)	grada completed)	leted) 16a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired) Manager			ation during most of v d)	working	16b. Kind of B			
		ne (First, Middle, L	ast)	1			18. Mother's N	lame (First, Middl	e, Maiden Surnar	ne)		
	Anthon	y Kotrla						Cumberla				
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	Ida Kotr						sant Av	e., Balt				
ment of H			3 □Removal from Statecify)	ceme	of Disposition etery, cremetor Stanis	ry or other plac	ce)	Date 5/4/99	20c. Location Baltimon			nd
Depart Import any in	21. Signature of	Funeral Service L Oscal	n. Ra	uning	Jos 263	eph No	ss of Fecility Zann onklin	ino Jr. g Stree	Funera t Balto	al H	ome d. 21	224
hysician	23a. Party Prote shipts or h	r the disease, or o eart failure. List o	complications that caus mly one cause on each	1/						1	Approxima Interval Be Onset end	te tween Death
/Medical	Immediate Caus disaasa or cond	tion		Severe	Chou	i Olsh	ntre P.	ulnung	Difease	_	years	
xaminer	rasulting in deet	h)	a	Due to (or as	e consequenc	ce of):		-	V	1	7	
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been signed by the attendin should be detached for use leted by Physician/N	h10	Courina	gling	; Hy	perter	sin		1/2	Yes 2□ No	3 Pro	bebly 4	Unknow
page 2 should								24a. Wa	s an eutopsy formed?	av	ere autopsy vailable prior empletion of death?	lo
page Con								10	Yes 25 No	11	□Yes 2D	(No
ector.	25. Was casa rai examiner?	erred to medicat	Handtol.			low		Death (Check only	one)			
00	1 Yes 2	No sath	Hospital: 1 Inpa		Outpatient 3	DOA Oth	4 LI Nursing	1	idence 6 DOt		fy)	-
After fune	1 Delatural	5 Pending	(Month, E	Day Year)	Injury	28c. Injur Wor	k? Yes 2 □ No	200. Describe	now injury occu	ilea .		
within 24 hours after deeth. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	3 Suicida 4 Homicid	6 ☐ Could no	ot be 28a. Place of I	Injury - At home, atc. <i>(Specify)</i>					(Street and Num own, State)	ber or Run	al Route Nur	nber,
within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physician: To the besi xaminer: On the besis and mannar:	of axamination	ige, death occ and/or investi	curred at the tir gation, in my o	ne, date and pla pinion, death or	ace, end due to the courred at the time	e cause(s) end m	anner es s end due t	stated. o the cause(s)
Nithin Somp	29b. Signeture a	nd title of certifier				29c. Licens	e number		29d. Dete signe	ed (Month,	Day, Year)	
		2. Lea	to us.			D	21460		5	1199		
	30. Name and ad	dress of person w	no completed causa of	death (Item 23)	a) (Type, Print	1)	, , (0)					
	ROBERT	LIBERTO, N	10. 3508	BANK 5	+ BA	1to 1	ud 2 10	724				
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DHMH 16 Rev 6/95

State

Registrar

111 Penn Street, Baltimore, Maryland 21201

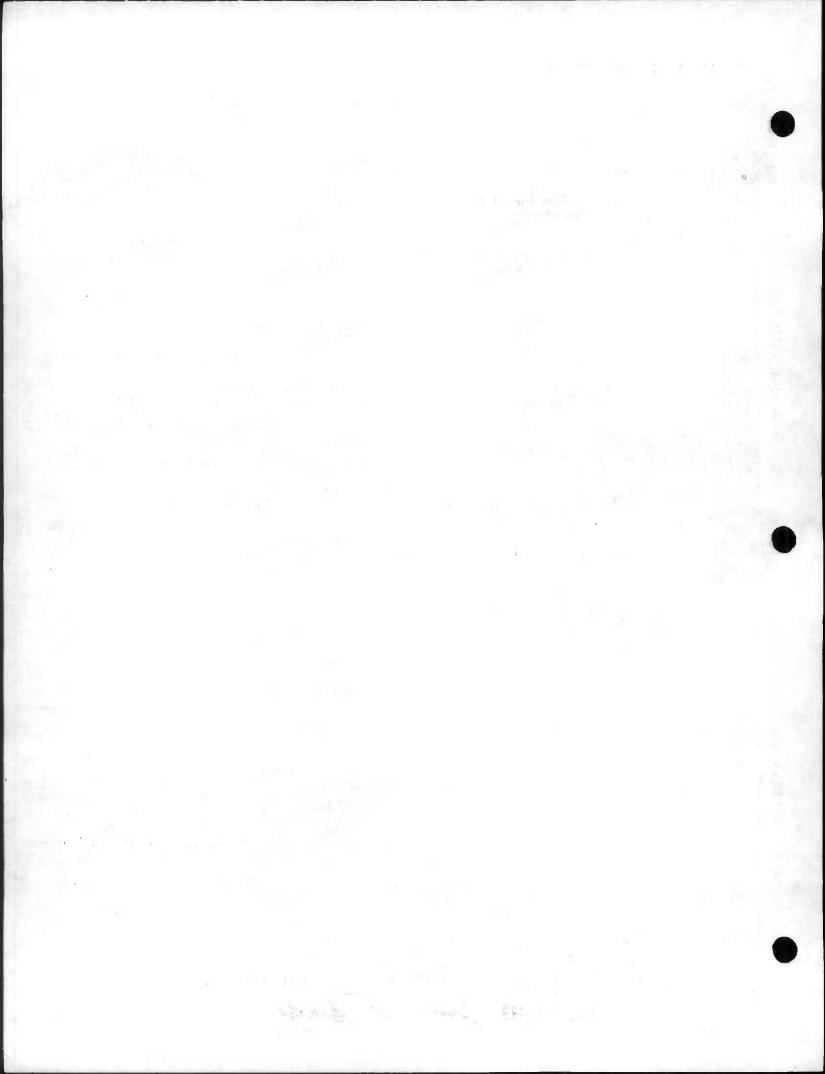
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kontu sus

32. Registrar a Bigneture

My Mor wop, A.

31. Data filed (Month, Day, Year)

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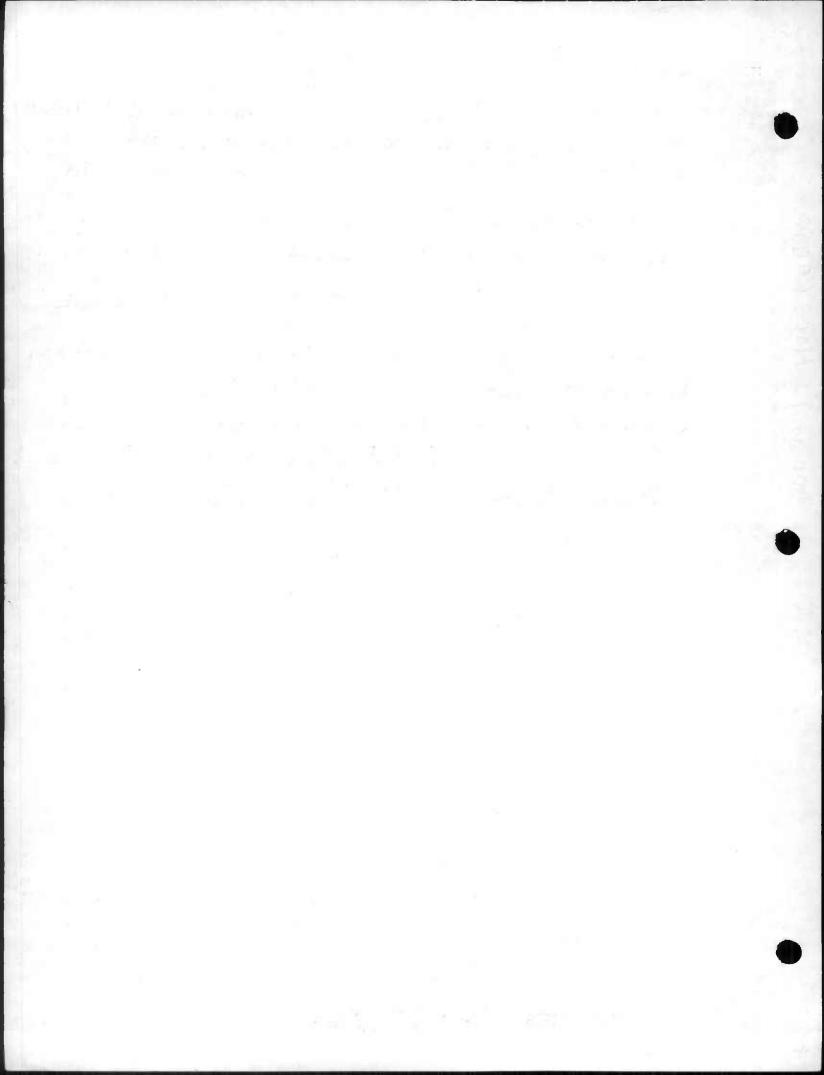


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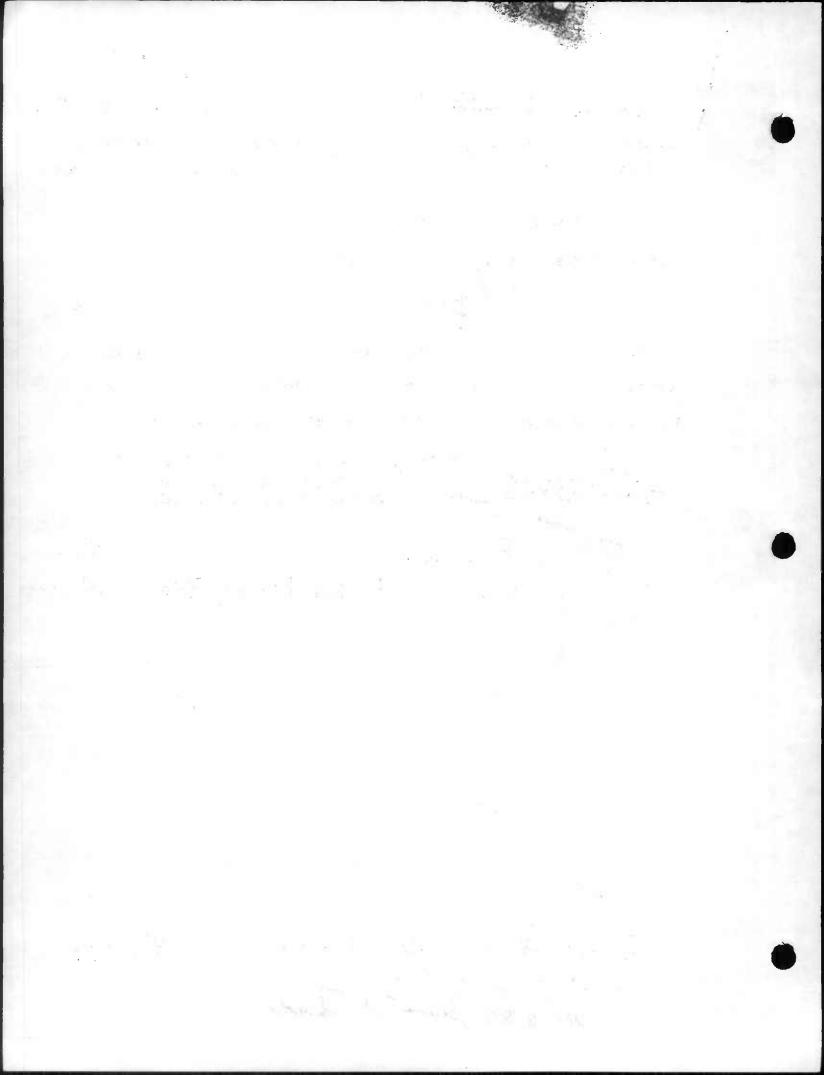
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State of	Maryland /	Department	of Health	and	Mental	Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month L **Physician** 50 reorge /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Fallston General Hospital Fallston Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours Yrs. 400-14-6566 83 29, 1916 Director Usuel Residence of Decedent with the Meryland 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Directo Harford Edgewood 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12. Wes Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 909 Woodbridge Ct. 21040 Funeral permit. Peges 1 end 2 should be filed within 72 hours efter death Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23 USA 14. Race - Americen Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: þ 3₺ Widowed 4 Divorced Year or Detes: WW-II White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Supervisor Carlary Glass Co. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Stewart MacIntosh Gladys Unknown 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Chip Edel/stepson 3803 Walters Rd. Edgewood, Md. 21040 Injury or other 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 5/1/99 Towson, Md. Hilltop Service Corp. 21 Signature of Funeral Sa Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Finel disease or condition resulting in deeth) neumonia **Examiner** Due to (or es e consequence of): Examiner Disease 165Tructive physician end s the burief-transit Sequentially list conditions, it eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): The law requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): for use es 98 signed by the e 23b. Did tobecco use contribute to the cause of death? Pert ff. Other afgnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Nos 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings available prior to completion of ceuse of deeth? 24a. Was an autopsy performed? page 2 s 1 ☐ Yes 2 No. 1 ☐ Yes 2 ☐ No this certificate • Hospital or Attanding Physician: 24 hours after death. • Funeral Director: After this certifice director, 25. Wes case referred to medical 8 26. Piece of Deeth (Check only one) examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpetient 3 DOA funerai 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation tnjury 1 Yes 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) completely filled in by 4 THomicide 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and plece, and due to the ceuse(s) and menner as stated.

2 Medical Exeminer: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29a. Certitier (Check only one) Medical To the I within 2 29b. Signeture and title of certifie, 29c. License number 29d. Date signed (Month, Day, Year) MD 536 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) himers unie 31. Date filed (Month, Day, Year) W 32. Registrar's Signature Registrar

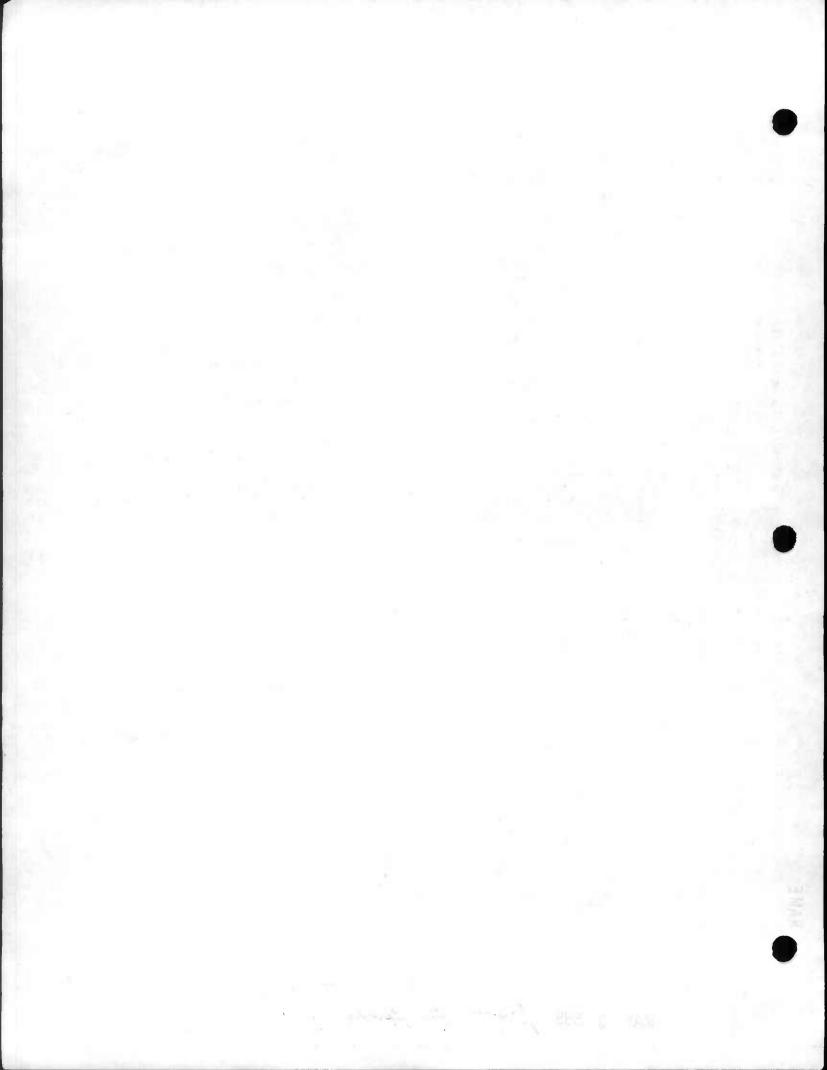


Piease Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Malling 1999 4b. City, Town, or Location of Death oh 6=30 am /Medical Name (If not institution, give and number 4c. County of Dea Examiner N/A Baltimore SDI ta Agne | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | October 13, 1906 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 215-07-4104 92 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or liems 23e or 28e-f sho the Medical Exeminer must be notified at 1 Yes 2 No Maryland Baltimore Baltimore Directo 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 4803 Carmella Drive 21227 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1941 hours after 1 Xes 2 No If Yes, Give TO Yeer or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglens. Elementary/Secondary (0-12) 6th College (1-4or 5+) Auto Store Salesman 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic even 88 Dola Benjamin H. Mattingly Gibbons 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvester G. Mattingly/Brother 4803 Carmella Drive Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery May3,1999 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. atural Homas 4107 Wilkens Avenue Baltimore, Maryland 21229 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or pear failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Causa (Final disease or condition resulting in death) /Medical umania Examiner Due to (or as a consequence of): Examine physician and the buriai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. cartificeta be Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? been signed by ti ehould be detech 1 Yes 2 No 3 Probably Winknown of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificeta hes 210 No 1 ☐ Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 20 No 10 1) Inpatient 2 ER/Outpalient 3 DOA 유 funarai 28a. Date of Injury (Month, Day Year) ner of Dea 28c. tnjury at Work? 28d. Describe how injury occurred Certification: After Division 1 Natural 2 Accident 5 Pending investigation or Attending efter deeth. Director: Att din by the fur 1 Yas 2 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital within 24 hours To the Funerel [adical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 bhr 30. Name and address of person cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 16 Ray 6/95

32. Registrer's Signat



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	unera irecto	
Maryland	a-f show	

traumetic event, the Medical Examiner must be no

John Meta bower

Physician /Medical Examiner

permit. Peges 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiana. Insportant: If item 27 is marked other than "naturel", or items 23a or items in items 27 is marked other than "naturel", or items 23a or items in injury or other traumatic event, the Hedgal Experience 23a or items in injury or other traumatic event, the Hedgal Experience. Be Examiner physician and the burial-transit The law requires that the death certificate be executed Box 68760. Physician/Medical for use es 980 P.O. signed b Records, ò Completed Division of Vital 80 P this funeral Medical Certification: or Attending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun State

Registrar

DHMH 16 Rev 6/95

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2.45Am MAY 1999 John Edgar Metzbower, Jr. 4e Facility Neme (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Burnie anne Arund North (7 Arunde HOSDITA P.VI Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yis. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Days Months 1X M 2□ F May 30, 78 Maryland 215-12-7045 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Queen Ann Maryland Oueenstown Direc 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21658 U.S.A. 120 River Run 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Merital Status 1 ☐ Never Merried 2 K Married 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Transit Company 12th Grade Diesel Mechanic 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Anderson John E. Metzbower, Sr. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 120 River Run Hilma Metzbower-Wife Queenstown, Maryland 21658 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Md. Vet. Cem. crownsvile 5/4/99 Crownsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Feneral Septice Licensee 22. Name and Address of Fecility McCully-Polyniak Funeral Home, P.A. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. MD Approximate Intervel Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) PHEUMONIA ASPIRATION Due to (or as e consequence of): ACCUDENT! CEREBRUYASCULAR Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of): CANCER METASTATIC PROGRATE thet initieted events resulting in death) Last Due to (or as e consequence of): ICAMAL ACUTE TAILURA Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown GI BLEED 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Tes 2 1000 1 ☐ Yes 2 No 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one)

Hospitel: 1 Sthpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Spark

345149 mis

MAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL DRIVE GUEN BURNIE MD 21061. ONABAJO.B

31. Dete filed (Month, Day, Year)

32. Registrar's Signeture

Sporks

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#10f perFH G771 5/3/99 EW 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day **Physician** 1999 12:55 PM McGee May 1, Beverly /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Baltimore Gilchrist Center Towson If Under 24 Hrs If Under 1 Year Birthplece (State or Foreign Country) Sociel Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dev. Yeer) **Funeral** Deys 1 M 2 XF Months Hours Yrs. 58 Director 217-38-7459 Nov. 12, 1940 Maryland Usuei Residence of Decedent 10d. Inside City Limits 10e. Stete 10b. County 10c. City, Town or Location ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 21222- 21122 1336 Edna Road U.S.A. Funeral death 12. Wes Decadent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Maritel Status 0 1 Never Married 2 Married 1 Yes 2 No Specify: Maryland 21215-0020 þ White 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) filed within Hygiena. N/A Disabled 11th Grade 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be should be is marked Ruth Virginia Appler Karl S. Richmond 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 Department of Haalth a Important: if Item 27 is any injury or other trat once. 21221 Karl S. Richmond-Father 1557 Alconbury Road Essex, MD 20b. Pleca of Disposition (Neme of cemetery, cremetery or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Pages 1 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from State 5/5/99 Elkridge Maryland Meadowridge Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licenses 3204 Mountain Road Pasadena, m D. 21122 hustina & Approximete Intervel Between Onset end Deeth 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical myeloma years Examiner Examin Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequença of) physician a the burla Physician/Medicai Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 8 E 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings eveilable prior to 24e. Wes en autopsy performed? Completed completion of cause of deeth? certificate has 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No P 5 funeral 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Certification: After Division 5 Pending 1 Natural 1 Yes 2 No investigetion or Attend after death Director: 2 Accident 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 4 | Homicide To the Hospital Within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pieca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pieca, end due to the cause(s) end menner steted. 29e. Certifier Medical (Check only one) 29b, Signature and title of cuff 29d. Date signed (Month, Dev. Year) 30. Name end eddress of person who completed cause of deeth (Ifem 23e) (Type, Print) W. A. K. (e.y. G. BM (676) N. 6701

State

Registrar

31. Dete filed (Month, Dey, Year)

1999

32. Registrer's Signeture

12:55pm

3)

May 1, 1999

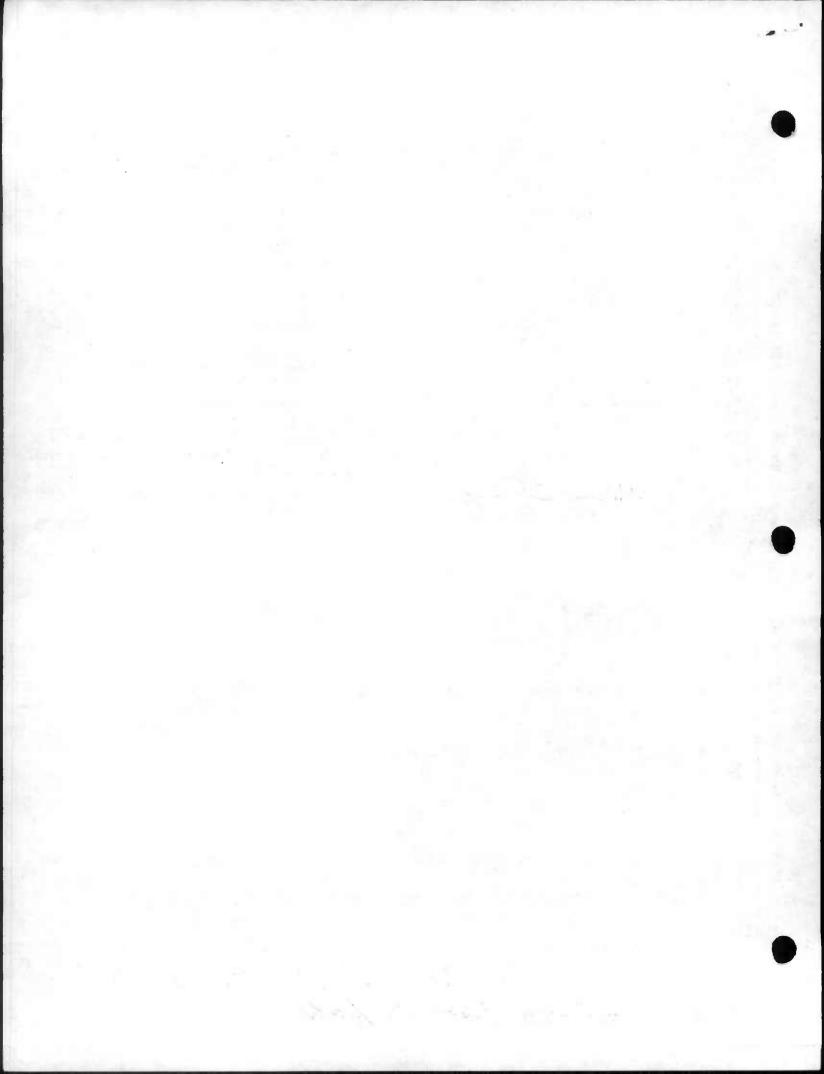
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death April 29, 1999 **Physician** Barbara 12:45 p.m L. Mays /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Overlea 5688 Leiden Road If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2-20-1945 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 X F Months Hours 218-42-6536 54 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits r than "natural", or items 23s or 26s-4 show Maryland Baltimore Overlea 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 5688 Leiden Road United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Evar in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Health and Mentel hygiene. Important: If Nem 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Estimates Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant / Bar Bartender 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Virginia Williams Robert S. Tate 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Andy E. Mays (son) Clover Valley Court Edgewood, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burlal 2 ☐ Cremation 3 ☐ Ramoval from Stata 5/03/99 Middle River, Maryland Holly Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Facility 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 21214 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** ASTATIC LUNG CANCER /Medical Immediate Cause (Final eass disease or condition resulting in death) Examiner Examiner ettending physicien and for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part ft. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Nos 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? pege 2 s 1 Yes 2 No 1 Yas 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) edicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/30/99 MD GOOD FRANKLIN SQUARE HOSPITAL BAUTIMORE MADHU CHAUDHRS MD 21237 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev Dominic Manzione 11:07am 1999 May 1, 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Atlantic General Hospital Berlin, MD Worcester If Under 24 Hrs. If Under 1 Year 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Months Deys Hours M 2□ F 75Yrs. 078-18-7725 Feb. 9, 1924 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Worcester Ocean City, Maryland 1 XXes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 106 Edward Taylor Road 21842 USA 12. Wes Decedent Ever in U,S. Armed Forces? XXD Yes 2 □ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Status Bleck, White, etc. Unk. 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usuel Occupation 15. Dacedant's Education (Give kind of work done during most of working lifa. DO NOT use retired) (Specify only highest grede completed) Elementary/Secondary (0-12) Collaga (1-4or 5+) Gas Station Owner Self Employed 12 18. Mother's Name (First, Middle, Maidan Surname) 17. Father's Name (First, Middle, Last) Sam Manzione Mary Sanfelice 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rose Manzione Wife 106 Edward Taylor Road, Ocean City MD 20b. Plece of Disposition (Name of cemetery, crametory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramoval from State Calvert National Cemetery May 6, 1999 Calverton, 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Charles L. Stevens Funeral Home, 21. Signature of Funerel Service Licensee Victor P. Doda, Jr. 1501 East Fort Avenue, Baltimore Maryland 21230 Approximete Interval Batween Onset end Death 23e. Pert1. Enter the diseese, or complications that caused tha deeth. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final diseese or condition resulting in daeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaase or injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of) 23b. Did tobacco usa contribute to the cause of death? Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Ware eutopsy findings eveilable prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case raferrad to medical examiner? 26. Place of Daeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Mannar of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Neturel 5 Pending

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Physician

Examiner

Funeral

Director

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Physician

/Medical Examiner

7725 DOB-2-9-24

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Certification:

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29a. Certifier

(Check only one)

Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

1 Yes 2 No 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, death occurred et fine time, date end plece, end due to the ceuse(s) end menner es steled.

| Medical Examiner: On the basis of axamination and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end menner stated.

29b. Signature end title of certifier

29c. License number

29d. Dete signed (Month, Day, Year)

Salisbury MD

21804

1 dum 30. Name and address of person who completed cause of death (Itam 36a) (Type, Print)

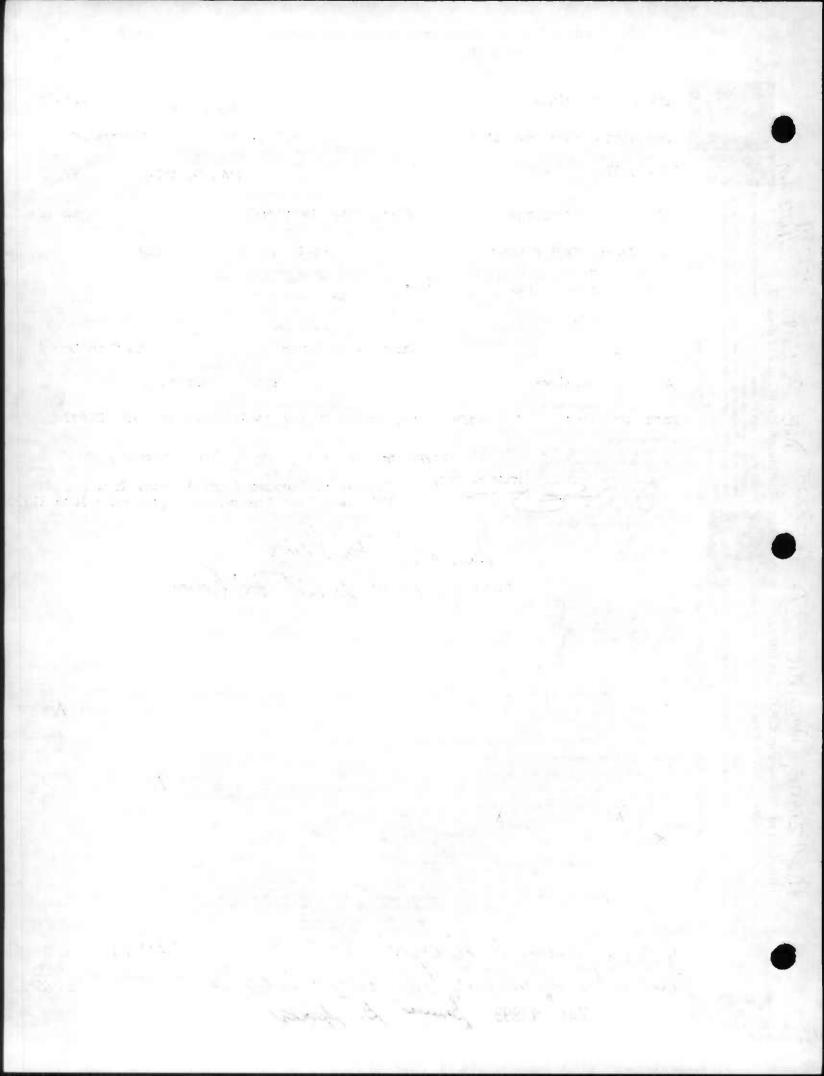
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Estern Shore Drive 32. Registrer's agnature

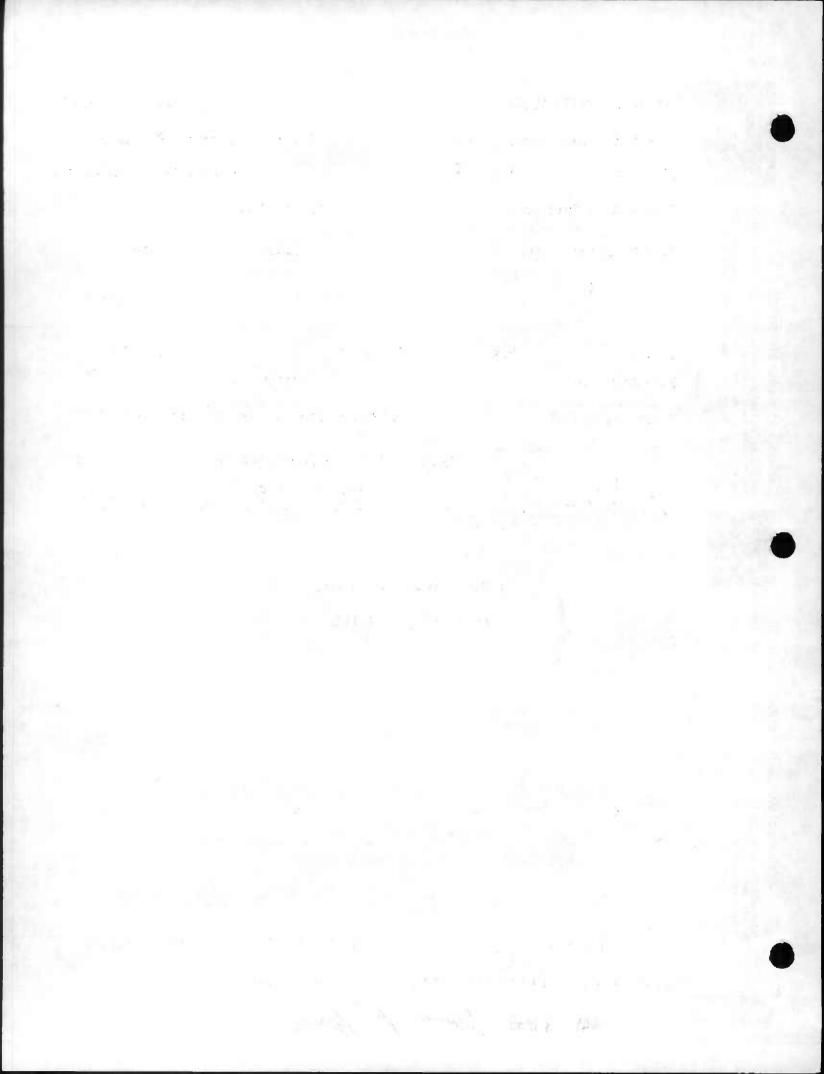
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iner	4a Facility Nama (If not institution,					4b. City, Town, or I	Location of Deat	h 4c. Count	y of Death	
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	5. Social Security Number 216-12-9293 Usual Rasidance of Decedant	1. Sex 7. A	nge (In yrs. last b	Yrs. Month		Hours Min.	8. Data of Bil (Month, De Oct. 8	y, Yaar) , 1923	9. Birthp Cour Ma	place (State or Foreign htry) ryland
or	10a. Stata 10b. County	timore	10c. City, To	wn or Location	Balt	timore Co	ounty		1	10d. Inside City Limits 1 ☐ Yas 2 🕅 No
Funeral Director	10e. Street and Number 3036 Moreland A	venue		10f. 2	Zip Coda	21234		10g. Citizan of US		ntry?
unera	11. Marital Status 1 Navar Marriad Marrie	12. Was Decedan Armed Forcas	37	13. Was Dao If Yas, sp	edent of Hoecify Cuba	lispanic Origin? (S an, Maxican, Puan	pecify Yas or No o Ricen, atc.)		ce - Amark ack, Whita,	
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To	19a. Informent's Neme/Ralationship Melvin S. Mille		15			a <i>nd N</i> um <i>ber or R</i> u land Aver				
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	4 □ Donation / 5 □ Other (Spa 21. Signature of F neral Sarvice Lie	, /	Morek	and Memo		Park 5	-3-1999	Balti	more,	Md.
edicai Examiner	2. Part. Enter the disease, or a shock, or heart failura. List or the disease or condition rasulting in death) Sequentially list conditions, if any, leeding to immediate ceusa. Enter Undarlying Causa (Disease or injury that initiated awants rasulting in death) Last	a. SE	Dua to (or as a Dua to (or as a SCLID	a consequence of	n: CER				7	Initiaryal Batween Onsat and Death
Physician/M		d								
Physi	Part II. Other significant conditions	contributing to death	but not rasulting	in tha undarlying	g causa giv	an in Part I.		tobecco use c Yes 2□ No		o the cause of death? bably 4 Unknown
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ation		288. Place of I	njury - At homa, atc. <i>(Spacify)</i>	farm, street, fact	ory, office			(Streat and Num wn, Stete)	nber or Run	al Routa Number,
Sertification	3 Sulcida 6 Could no datarmin			as death occurre	d at tha tir	ma, data and place	, and dua to the	ceusa(s) and n	nannar as s	steted.
dical Certification:	4 Homicide datarmin	Phyalcian: To the bes aminer: On the basis and manner:	of axamination a	nd/or invastigati	on, in my o	pinion, daam occu	irred at the time			O (na cause(s)
Medical Certification:	4 Homicide datarmin 29a. Cartifiar (Check only 2 Medical Ex	aminer: On the basis	of axamination a	nd/or invastigati	on, in my o		28	29d. Data sign	ad (Month,	Day, Year)
edicai	4 Homicide datarmin 29a. Cartifiar (Check only one) Certifying 2 Medical Ex	aminer: On the basis and manner s	of axamination astatad.	nd/or invastigati	on, in my o	sa number		29d. Data sign	ad (Month,	Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Dey Month Blanche Mills 10:20pm 1999 Apri Maggie 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth City 40501 Alfimore
If Under 24 Hrs. 8 N/A Johns 40 If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 ☑ F 85 217-03-8378 15, July Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A No 2 No BALTO 10f. Zip Code 10e. Street end Number 10a, Citizen of Whet Country? 21213 U.S.A. 1500 N. ELLWOOD AVE 13. Was Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Maritel Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: BLACK Specify: 3X Widowed 4 ☐ Divorced 16a. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic 6th Housewife, Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) Horace Harris Maggie Wright 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20b. Pleca of Disposition (Neme of cametery, crematory or other place)

1500 N. Ellwood Ave Balto, Md. 21213

20c. Location - City or Town, Stete John Mills, 20e. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ Removel from State MD National Mem PK 4-30-99 Laurel, Md 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee Betts Funeral Home 1129 N Caroline St Balto, Md 21213 accor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset end Deeth Immediate Ceuse (Final 2945 Pulmonany edema disease or condition resulting in deeth) Due to (or es e consequence of): 295 Myocardial Interction Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequenca of): tailure 2473 Acute renal Due to (or es e consequence of): failure months renal Chronic Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1□ Yes 2⊡ No 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident

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Physician

/Medical

Examiner

Director

Funeral

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Director

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Pages 1 end 2 should be filed within 72 hours efter death with the Merylei nent of Health end Mental Hygiene.

Int: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any or other traumatic event, the Medical Examiner must be not if a district.

permit. Pages 1 end 2 Department of Health el Important: if Item 27 is any injury or other trai

Physician

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Certification:

altimore, Maryland 21215-0020

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physicien end s the bunal-tren attending pl ed by the a signed I Deen certificate Attending Physician: this After Hospital or Attending 24 hours efter death. Funeral Director: Aft

page 2 should Completed

director.

Division of Vital 24 hours

edicai To the Hosp within 24 hou To the Fune completely fi

State

Registrar

31. Date filed (Month, Dey, Year)

29b. Signature and title of cortifier

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

6 Could not be determined

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Tower 110, Johns Hopkins Hospital, 100 North Wolfe Street, Baltimore, Maryland 21205

1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) and manner stated.

29c. License number

RES-000

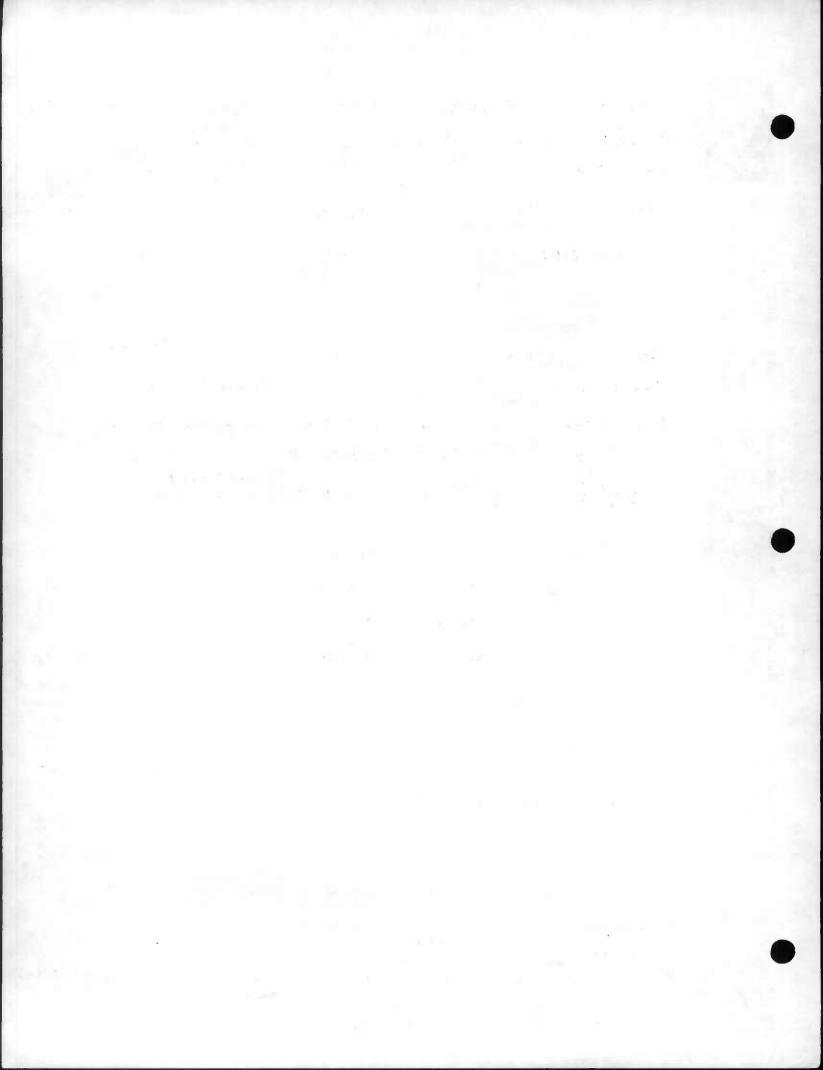
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Yeer)

April 25, 1999

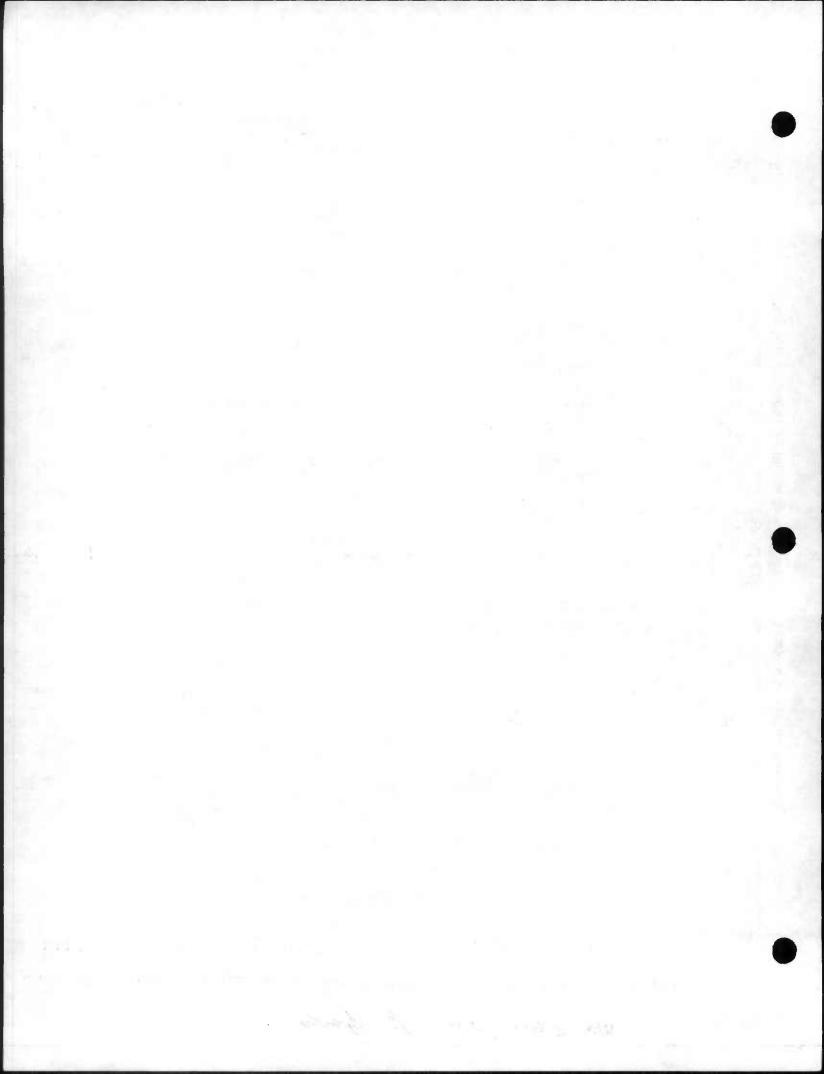
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

M.D.



	Decedent's Nama (First, Middle, L.)	astl		Certificate of	Death	2. Dete of Deet	g. No.		3. Time of Death		
sician	Betty	Jean	Nooe			Month ADril	29 19	Yeer	9:25 PM		
edical miner	4e Facility Neme (If not institution, g				4b. City, Town, or L		4c. County		9.23 FII		
	1554 Long Point	Rd.			Pasader			nne A	rundel		
il r	5. Social Security Number 216-42-4437 Usual Residence of Decedent	Sax 7. A	nge (In yrs. last birth 54 Y	day) If Under 1 Yaar Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, NOV . 21	, 1944	9. Birthpl Count Mary	ace (Stete or Foreign for) Tand		
rector	10a. Stete 10b. County		10c. City, Town	or Location		10d. Inside City Lim					
tor	MD Ann	e Arundel		Pasade	na				1 ☐ Yes 2 No		
)irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of V	Vhet Count	try?		
ral	1554 Long Poi	nt Rd.		2112			US	SA .			
by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Deceden Armed Forces 1 Tyes 2 If Yes, Give Yeer or Datas	XNo	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yas 2 ☐ No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		e - Amarica k, White, e			
sted	15. Decedent's I	Education reda completed)	16a. [Decedent's Usuel Occup	pation during most of work	kina	16b. Kind of Bu				
Completed	Elemantery/Secondary (0-12)	Collega (1-4or	r 5+)	Give kind of work done life. DO NOT use retire	d)						
S	17. Fathar's Name (First, Middle, Las	(1)		Nurse	18 Mather's New	Nursing Home other's Nema (First, Middle, Maiden Sumeme)					
o Be	Ellis	Clyde	J	ohnson	Virgi		uise	Harr	ison		
2	19e. Informent's Name/Ralationship			Meiling Address (Street							
reportant: If them 27 is marked other any Injury or other traumatic event, once. To Be C	Walter Nooe J	r - hushar		54 Long Po							
	20e. Method of Disposition		20b. Place of I	Disposition (Neme of cremetory or other ple	1			City or Town, State			
	1 Buriel 2 Crametion 3 4 Donetion 5 Other (Spec			Crematory	Inc.	5/3/99	Baltim	ore.	Md.		
	21. Signature of Funeral Service Lice	ensee	7.	22. Name and Addre	ss of Fecility	D.4					
	Muschell	Stall	ad)	Stallings 3111 Mount	Funeral H ain Rd. P	ome PA asadena,	Md. 21	1122			
Examiner	Immediate Ceuse (Finel disease or condition rasulting in deeth)	e	Due to (or as a co						4 Month		
edicai	Sequentielly list conditions, if any, leading to immediate cause. Enter Underfying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as e consequence of): Due to (or es a consequence of):										
Physician/M	Part II. Other significant conditions	dcontributing to death	but not resulting in	the underlying causa giv	ven in Pert I.	23b. Did to	bacco uae co	ntribute to	the causa of death		
P.						112Ye	8 2□ No	3 Prob	ably 4 🗆 Unknow		
Completed by						24a. Wes ar perform		ava	re autopsy findings illable prior to npletion of cause seath?		
E						1 ☐ Ye	s 200 No	10	Yes 2 No		
Be	25. Wes casa referred to medical examiner?					th (Check only on	a)				
2	1 Yes 2 No	Hospitel:			4 In Nursing H		nce 6 Oth)		
Certification:	27. Manner of Death 1 Waturel 5 Pending 2 Accident investigetic 3 Suicide 6 Could not		jury 28b. Tie ey Year) Inj	ury Wo	y et rk? Yes 2 □ No	28d. Describe ho					
Cerili	4 Homicide detarmine	259. PIECE OF IT	njury - At home, fem itc. <i>(Specify)</i>	n, street, fectory, office	28f. Location (Sti City or Town	f. Location (Street and Number or Rurel Route Number, City or Town, Stete)					
Medical	29a. Certifier (Check only one)	hysician: To the best miner: On tha basis of and menner s	of axamination and/ teted.	deeth occurred at tha ti or investigation, in my o	ppinion, death occur	red et the time, da	ite end plece,	and dua to	the cause(s)		
M	29b. Signatura and title of certifiar	eas M	·D.	ype, Print) ain Imy A. Span	39505	- P	d. Date signed	d (Month, L	Day, Year)		
	30. Name and address of person who Yudhish Mar		deeth (Item 23a) (T	ype, Print) ain flue	#602,	Glen B	burn	4 1	1D. 2106		

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY **Physician** NEIGHOPP SERNARD /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5543 Gayland Road Baltimore Arbutus If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (Stat Country) April 2, 1920 Maryland 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Deys Months 1⊠M 2□ F Hours 216-18-3117 79 Director Usuei Residence of Decedent deeth with the Maryland 10a. Stete 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 10d. Inside City Limits Baltimore Arbutus Director 1 Yes 2 No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 5543 Gayland Road 21227 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meritel Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Item any Injury or other traumatic event, the Medical Expension Black, White, etc. 1 K Yes 2 No WWII If Yes, Give WWII Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: p 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician U.S. Coast Guard 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles H. Neighoff Mary (unk) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Roberta E. Neighoff (Wife) 5543 Gayland Road, Arbutus, Maryland 21227 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □Removel from Stete 5/4/99 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore National Baltimore, Maryland 21. Signature of Funerel Service Licensee 22. Name end Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 Lemmer 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final diseese or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or es a consequence of): USB 85 Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? s been signed by to 2 should be detach 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? page 2 2 No 20 No 1 Yes certificate Hospital or Attending Physician: 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation Natural within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier ŝ 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certified 29c. License number 30. Nerpe and address of person who completed cause of deeth (Item 23a) (Type, Print) CAPMUTSU 31. Dete filed (Month, I 3 1999 Day, 32. Registrer's Signeture State Registrar

many & --- op's van

1. Decedent's Nama (First, Middla, Last) **Physician** ROBERI NICHOLLS /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Deeth **Examiner** BALTIMORE CENTE SHOCK TRAUMA BALTIMORE If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) If Undar 1 Yaar 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Months Days 11 M 2□ F 051-38-5952 52 Sept. 22, 1946 Director Usual Rasidenca of Decedent with the Marylend 10c. City, Town or Location 10a Stata 10b. County tem 27 is marked other than "naturel", or items 23s or 28s4 show other traumstic event, the Medical Examinar must be notified at MD Howard Columbia Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5451 Wild Wind Place 21045 U.S.A. Funeral deeth permit. Pages 1 and 2 should be filed within 72 hours effer deel Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature!". Any injury or other traumatic events. 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ☒ No Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, 11. Marital Status Bleck, Whita, atc. 1 Navar Marriad 2 Married Specify: Black 1 ☐ Yas 2 ☒ No Specify: p 3 ☐ Widowed 4 ☐ Divorcad Year or Datas Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Assistant Director S.B.A. 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Father's Nama (First, Middla, Last) Herbert E. Nicholls, Sr. Cynthia O. RObinson 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) Phyllis Brogdon-Nicholls (Wife) 5451 Wild Wind Place 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State Balto-Washington Crematory 5/3/99 Laurel, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility Witzke Funeral Homes, Inc. 21. Signatura of/Funaral Servica Licensea 5555 Twin Knolls Road, Columbia, MD 21045 bande. Semmer 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician SEPTIC SHOCK /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner SOFT TISSUE INFECT. Examiner physician end s the buriel-transit

48 hours

3. Tima of Death 924

Birthplaca (Stata or Foreign Country)

10d. Insida City Limits

1 ☐ Yas 2 No

New York

Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last

Physician/Medical

by

Completed

Be

2

Certification:

Medical

as

signed by the e

funeral

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PINEUMONIA, ENDSTAGE RENAL DISEASE

HYPERTENSION, DIABETET MELITUS

23b. Did tobacco usa contribute to the cause of death?

3 Probably Unknown 1 ☐ Yes 2 ☐ No

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 TYAS 2 No

1 □ Yas 2 □ No

25. Wes case rafarred to medical axaminar? 1 Yas 2 No

5 Panding invastigation

6 Could not be data minad

Hospital: Data of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Tima of Injury

Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

Dua to (or as a consaquanca of):

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Spacify) 28c. Injury et Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how Injury occurred

26. Place of Daeth (Check only ona)

Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifian (Check only one)

27. Manner of Daath

Naturel

2 Accidant

3 Suicida

4 Homicide

* Sertifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) end menner es steted.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifiar

MAY

29c. Licansa number

29d. Data signed (Month, Day, Year)

3 1999

51654

99

30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print) CENTER

SHOCK TRAUMA 31. Data filed (Month, Day; Year)

32. Registrar's Signatura

requires that the deeth certificate be executed P.O. Box 68760 Records, Division of Vital or Attending Physician: efter deeth. Director: After this certifica

State

To the Hospital or Atterview within 24 hours effer de To the Funeral Directo completely filled in by the

Registrar

25 30 17 10 10 10 10 10 10 10 and the state of t AND THE STATE OF THE STATE OF THE no were just to spece

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 1999 Anna Oefele 8:55 am 4b, City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) TOWSON BALTIMORE GREATER BALTIMORE MEDICAL CENTER If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5 Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) 1□M 2XF 94 Yrs. 152-03-3819 November 23,1904 Bucken, Germany Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Co. Phoenix Maryland 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? United States of America 4004 Eland Road 21131 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 XNo Specify: White Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 Home Maker Own Home n/a 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) August Boedecker Sophie Frazer 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. tnforment's Neme/Reletionship (Type, Print) Phoenix, Maryland Mrs. Elsa Peterson (Daughter) 4004 Eland Road 20b. Place of Disposition (Neme of cemetery, cremetory or other p 20c. Location - City or Town, Stete 20e. Method of Disposition 1 X Buriel 2 ☐ Cremetion 3 ☐ Removal from State Graceland Memorial Park 5/05/1999 Kenilworth, New Jersey 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. Jeffrey L. 1050 York Rd. Towson, Md. 21204 an 23e. Pan1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart favore. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Due to (or es e consequence of): 23b. Did tobecco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yea 3 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 25. Wes case referred medical exeminer? 26. Piece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpetient 3 DOA 27. Mapmer of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specity) 4 Homicide

certificate be executed Records, Tha law requires Division of Vital Physician: or Attending

attending physician end for use as the bunal-transit signed by the a peen s certificata has this s after daath. funeral filled in by

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Funeral

Director

item 27 is marked other than "natural", or items 23s or 23s-f show other traumstic event, the Modical Examiner must be notified at

pemit. Pages 1 and 2 should be filed within 7; Depertment of Health and Mental Hygiena. Important: If item 27 is marked other than "na any injury or other traumatic event, the Media page.

Physician /Medical

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Physician/Medical Examiner

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Certification:

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within 24 hours of To the Funeral I

State Registrar

29b. Signeture end with of certifier

29c. License number

Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end manner es steted.

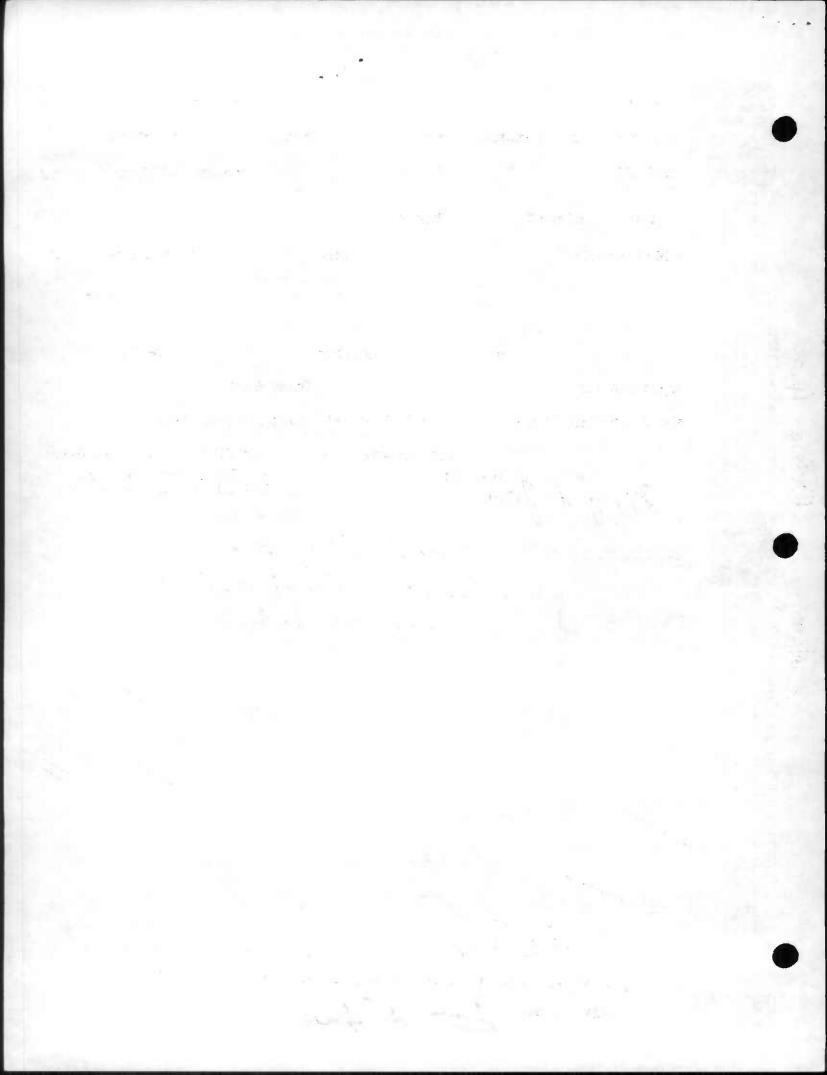
2 Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end manner steted. 29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

Rajesh V. Raikar, M.D. 6801 Belair Road Baltimore, Maryland 21206

31. Date filed (Month, Day, Year) MAY

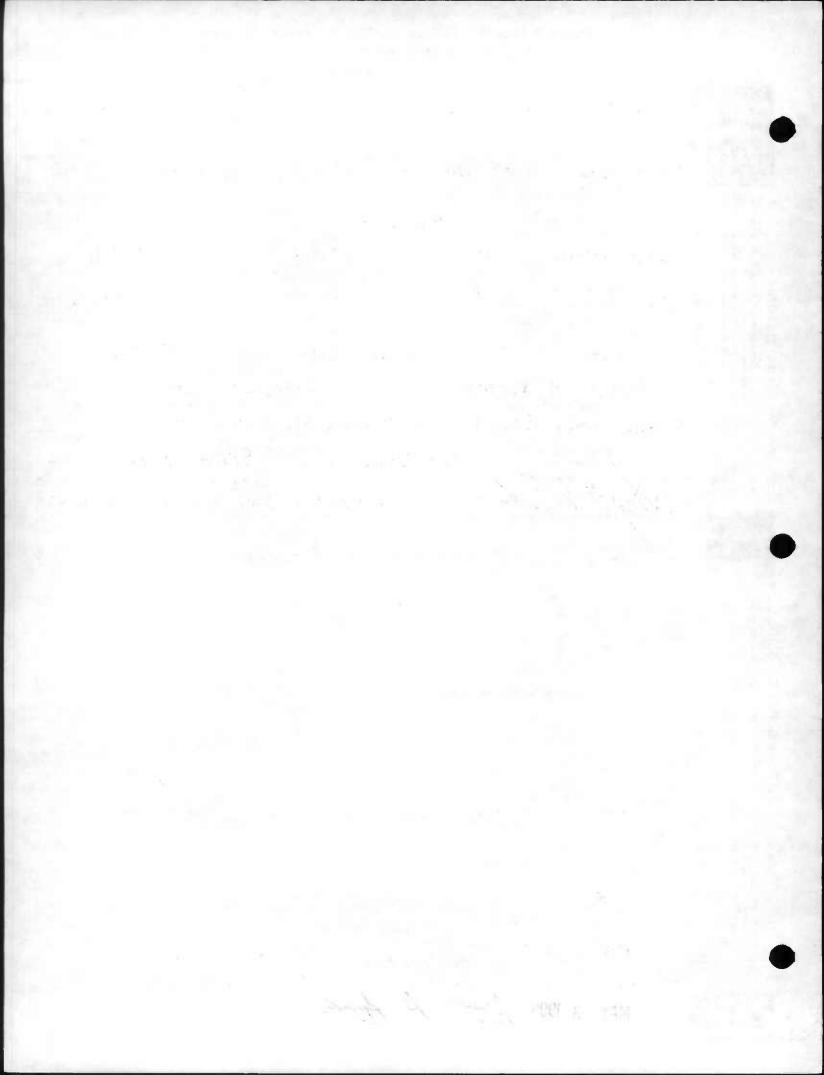
32. Registrar's Signature.



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			Certifica	te of Death		Reg. No.							
Physician	10011	Parker			2. Dete of De	Day	Yeer 801						
Medical/ Examiner	4a Fecility Neme (If not institution, give			4b. City, Town, o	r Location of Deet	4c. County o	of Deeth						
uneral	5 Societ Security Number 6. S			er 1 Year If Under 24 H		th	9. Birthplace (State or Fo						
irector	H3.61 3030	□M 20XF 44	Yrs. Months	Deys Hours Mi	n. (Month, De	154	Country) MD						
w m	Usuel Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Li						
notfied at	MD N/A	B:	altimore				1 V Yes 2						
3a or 2	10e. Street and Number 2913 Boarman	AVE	101. 2	17 15		10g. Citizen of W	het Country?						
r tems 23a or 28a-fa niper must be notified Funeral Director	11. Merifel Stetus	12. Wes Decedent Ever in U,S. Armed Forces?	13. Was Dec	edent of Hispenic Origin? ecify Cuban, Mexican, Pur	(Specify Yes or No erto Rican, etc.)	- 14. Rece Bleck	- American Indian, t, White, etc.						
Example by Fi		1 Yes 2 No If Yes, Give Yeer or Detes:	1□ Yes	2 No Specify:		Specify:	Black						
			16a. Decedent's Us (Give kind of w	rork done during most of w	vorking	16b. Kind of Bus	siness/Industry						
- 51	Elementary/Secondery (0-12)	College (1-4or 5+)	Private	- 1		NUTSI	V9						
marked out	17. Fether's Neme (First, Middle, Last)	A	1111001		eme (First, Middle	, Maiden Sumeme))						
	Nathaniel B. Yarker Catherine Clary 19a. Informent's Neme/Reletionship (Type, Print) 19b. Maiting Address (Street end Number or Rural Route Number, City of Town, Ste												
T T	UNIQUE LONES	(Daughter	2913 Boar		altimore	10. 1	_1215						
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐	Removel from State	ce of Disposition (N netery, cremetory or	ame of other place)	Dete	A 1	City or Town, Stete						
Important: If i any injury or once.	4 Donetion 6 Other (Specify 21. Signeture of uneral Service Licen	773M			5/4/99	Catons							
any ir	March M	1/				march timons.	FUNERAL H						
	23a. Parl Prior the disease, or company should heart failure. List only	ptications that caused the death.					Approximete theree theree						
sician edical	tmmediate Ceuse (Final disease or condition	subar	rachnoi	d hemor	hage		Onset end Dee						
miner a	resulting in death)		es e consequence o		8								
n and iel-transit	Sequentially tist conditions.	b. Due to (or e	es e consequence of):									
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gned be deta					TO YES ZONO SOPPOBERY 43 OF								
sete hes been signed be page 2 should be detected by Poster Completed by P					24a. Was	en autopsy ormed?	24b. Were autopsy findi eveileble prior to completion of caus						
page 2 s				10	Yes 2 No	of deeth?							
certificete hes rector, page 2	25. Wes case referred to medical			26. Plece of I	eath (Check only		1 163 2 100						
Pis di	1 □ Yes 2 No		R/Outpatient 3□ [Home 5 Res								
After fune tion	27. Menner of Deeth Naturet 5 Pending Accident investigation	(Month, Day Year)	8b. Time of Injury M	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred								
by the fu	3 Suicide 6 Could not be determined		e, ferm, street, fecto	ory, offica	28f. Location (Street end Number or Rurel Route Number, City or Town, State)								
Illed in	200 Cortifies Ad Cortificion Di		adaa daath assussa	d at the time date and pla									
within 24 hours efter deeth. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner es steted. Check only one) Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated.												
Me Fundales	one)		2	9c. License number									
To the Funeral Director: completely filled in by the Medical Certificat				DM D P12316 April 29, 1999 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) DM Fedor 2141 W. Belve Leve Ave. Balkmore, MD 21215									
To the Function of completely i	29b. Signeture end title of cartifier		21.5	P1231	6	April :	29, 1999						
To the Function of the Functio		completed cause of deeth (Item 2	(Type, Print) EHE Ave	P1231.	6 MD	April 3	29, 1999 5						

DHMH 16 Rev 6/95



Examiner law raquiras that the death certificate be executed Division of Vital Records, P.O. Box 68760, ne Hospital or Attending n 24 hours aftar death. he Funeral Director: Afte pletely filled in by tha fun

Physician

/Medical

Examiner

Directo

Funeral

Completed

Be

2

Examiner

Physician/Medical

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Completed

Be

2

Certification:

Medical

State Registrar

Funeral

Director

or items 23a or annual be r

TEPLOL JOHN

Pages 1 and 2 should

Department of Health important: If item 27

Physician

/Medical

physician and s the burial-transit

is certificata has director, paga 2

this funeral

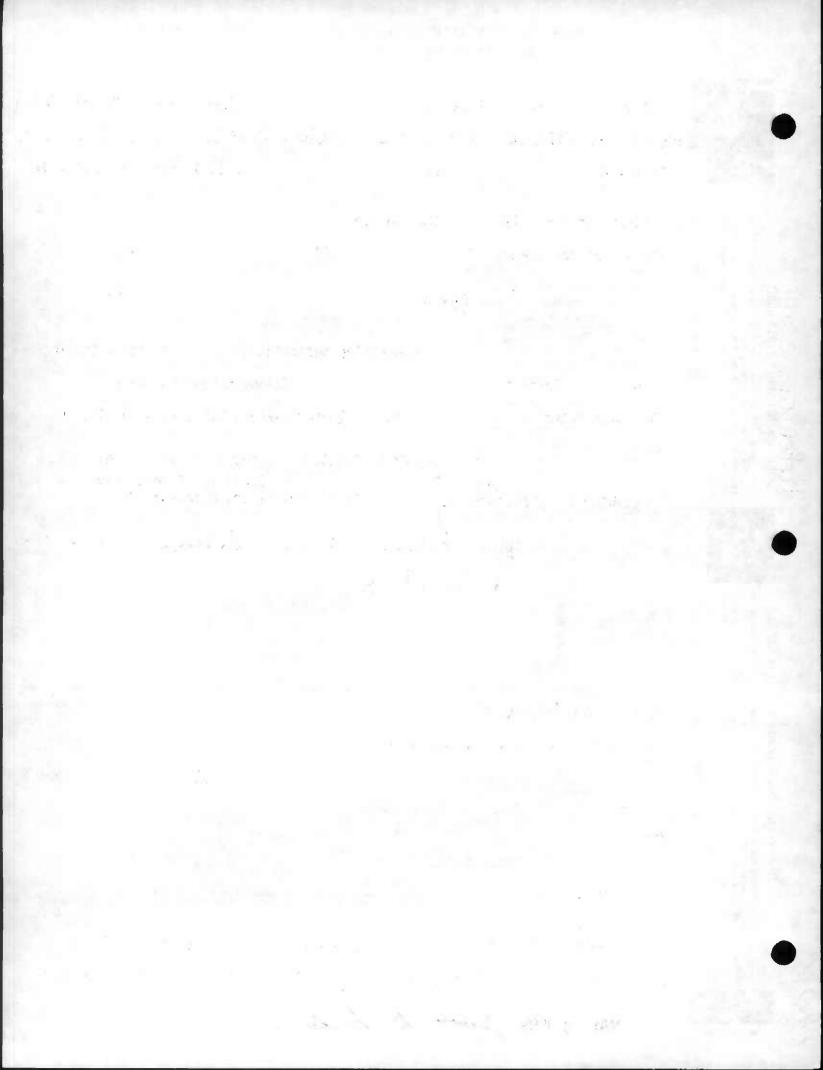
To the Hospi within 24 hou To the Funer completely fil

DHMH 16 Rev 6/95



30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 301 Hosp. Hr BOA; TE-32. Registrar's Signature 31. Date filed (Month, Day, Year)

m Burnie MU 21061



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Daeth 3. Time of Death **Physician** Month Dey Alexander Puciato April 27, 1999 7:35PM /Medical 4e. Fecitity Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Forest Haven Nursing Home Catonsville Baltimore Hours Min. 8. Data of Birth (Month, Day, Year, Sept 22, 1 5. Social Security Number If Under 1 Yeer 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** 1 M 2 □ F Days 220-18-9254 Vrs Director 71 1927 Maryland Usuel Residence of Decedant 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examiner must be notified at MD Director 1 X Yes 2 No Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2150 Harmon Avenue 21230 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 🖺 Divorced Completed 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usuat Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) House Painter Painting 10 permit. Pages 1 and 2 should be filed.
Department of Health and Mertal Hygis.
Important: If Item 27 is marked other 1
mny Injury or other traumetic event. Item. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be George Puciato Anna Matusewicz 19a. Informant's Name/Reletionshtp (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Coda) John Puciato, (BROTHER) 2150 Harmon Avenue, Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removel from Steta Baltimore Wash. Crematory 5-1-99 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funaral Servica Licensee 22. Name end Address of Facility Witzke Funeral Homes, Inc. Manda 1630 Edmondson Avenue, Catonsville, MD 21228 Lenn 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer failura. List only ona cause on each lina. Physician ROSTATE /Medical Immediate Ceuse (Final diseasa or condition rasulting in deeth) Examiner Due to (or es e consequence of) Examiner The law requires that the death certificate be executed Sequentielty list conditions, if any, laading to immadiate causa. Enter Underlying Ceuse (Diseese or injury that initiated avants resulting In death) Last end Due to (or es e consequença of) P.O. Box 68760. ettending physiclan for use es the burier Physician/Medical Due to (or as e consequence of): signed by the e Pert II. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Wrtknown Records, þ 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? peen hes page 2 1 🗆 Yes certificete 1 ☐ Yes 2 ☐ No Division of Vital al or Attending Physician: T s efter deeth. it Director: After this certificet ed in by the funeral director, pi 25. Was case refarred to medicat examinar? Be 26. Plece of Deeth (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding investigation 1 Naturat 1 Tyes 2 TNo 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Spacify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Steta) 4 Homicida within 24 hours eft To the Funeral Di completely filled in To the Hospital Medical 29a. Certifia Certifying Phyeicien: To tha best of my knowledga, deeth occurred et tha time, data end plece, and due to tha cause(s) end mannar as stated.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred et tha time, data end placa, end due to the ceuse(s) and menner stated. 29b. Signalus and title of certifier 29d. Date signed (Month, Dey, Year) 30 Nama end address of person who completed cause of deeth (Item 23e) (Type, Print)

ALLIANI 7220 PARK ELCHTS AVE BAI

Registrar

State

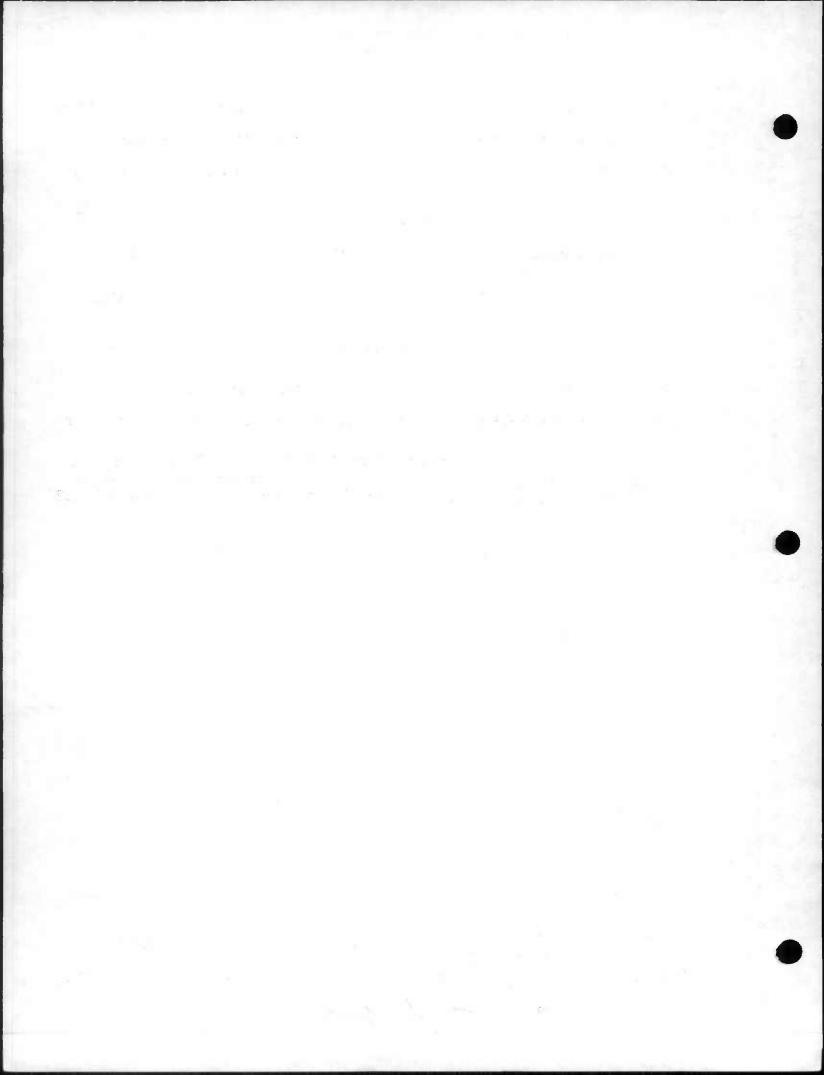
31. Date tiled (Month, Dey: Year)

MAY

3 1999

32. Registrer's Signature

Juans



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 126 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Month PAGANI 3:02 PM JOH N 1999 29 4b. City, Town, or Location of Death 4c. County of Death 2/239 BRITIMIRE 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) MOM 20 F MARYLAND

1. Decedent's Name (First, Middle, Last) **Physician** CHARLES /Medical 4a Facility Name (If not institution, give street and number) Examiner GOOD SAMBRITAN HOSPITAL, BACTIMORE H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/15/19 5. Social Security Number **Funeral** Yrs. Director 219-03-3643 Usual Residence of Decedent r 25a-f show 10a State 10b. County 10c. City, Town or Location MD N/A BALTIMORE CITY Directo 2 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23s or the Medical Examiner must be r USA 1636 BURNWOOD ROAD 21239 Funeral 12. Was Decedent Ever in U,S. Armed Forces? ★★Yes 2 □ No If Yes, Give Yeer or Dales: WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Black, White, etc. hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ WWII 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. than Elementery/Secondary (0-12) College (1-4or 5+) AUTO TRIMMER GENERAL MOTORS CORP 9th GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) should be fi and Mental f marked JOHN PAGANI **EMMA** FOCACCIA Bud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 an Cepartment of Health and Important. If tem 27 is in any injury or other traum once. JOAN M. PAGANI BALTIMORE, MD WIFE 1636 BURNWOOD ROAD 21239 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ₺ Burial 2 ☐ Cremetion 3 ☐ Removal from State 5/3/99 4 ☐ Donation 5 ☐ Other (Specify) COCKEYSVILLE, MD DULANEY VALLEY MEM. GAR. 21. Signature of Funeral Service Licanses 22. Name and Address of Facility JOHNSON FUNERAL HOME, P.A. lea the tai 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. PAM. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical SEPSIS Examiner Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last pue Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Due to (or es a consequença of) 23b. Did tobacco use contribute to the cause of death?

that the death certificate be executed

ed by the a signed by the law requires peen has The certificate Physician: funeral director, this After in 24 hours after death.
The Funeral Director: After an by the fu Attending

Division of Vital

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Completed

Be

Certification: To

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Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

ISCHEMIC CARDIOMYOPATHY

COOGULOPATHY

24a. Was an autopsy performed?

26. Plece of Death (Check only one)

1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Approximete Interval Between Onset and Death

Iday

10d. Inside City Limits 1 Yes 2 No

2 No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of deeth?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? 1 Yes 2 No 27. Menner of Death 1 Naturel
2 Accident

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

Hospital: 1 Hnpatient 2 □ ER/Outpatient 3 □ DOA 28b. Time of

Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Sulcide

4 - Homlcide

**Cortifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier

AJAY CHAWLA.

29c. License number -12556 29d. Date signed (Month, Day, Year) MRIL, 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

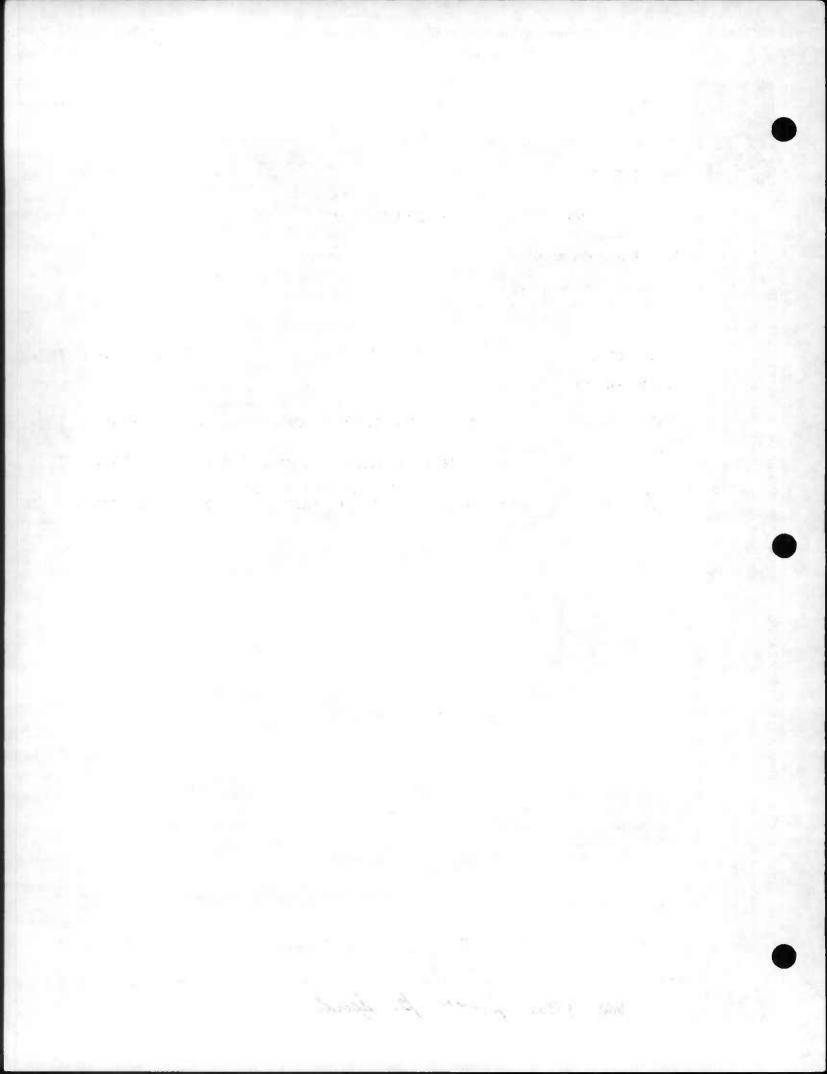
GUOD SAMBRITAN HOSPITAL LOCHRAVEN RLVD BALTIMORE MD ATAY CHAWLA, MD

Registrar



DHMH 16 Rev 6/95

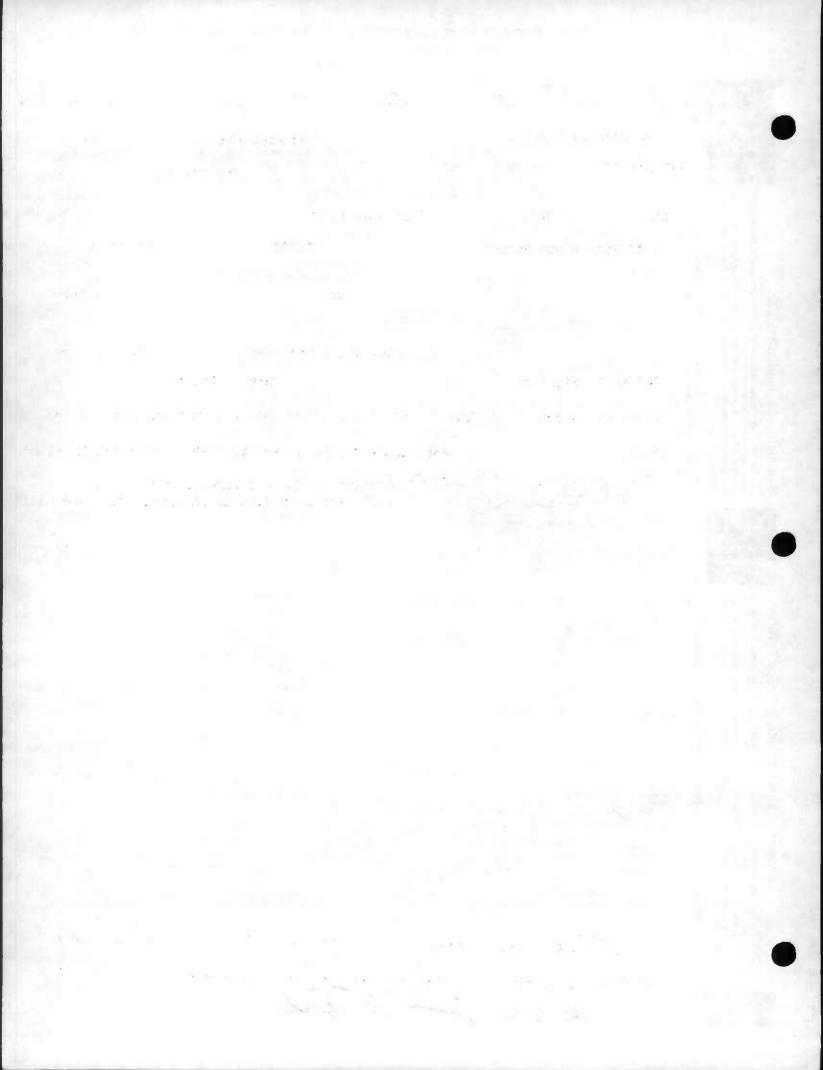
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State of Maryland / Department of Health and Mental Hygiene 9

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					Cei	tificat	e of i	Death		Re	eg. No.		
Physician /Medical	1. Decedent's Neme (First, A	210	-+/		2. Dete of Deet Month	h Dey	Yeer 1999	3. Time of Death					
Examiner	4a Fecility Neme (If not Institute John Hopkin	-		ber)				Balti	more	city	4c. County		J/A
Funeral Director	5. Social Security Number 216-05-9037	6. Sex 1 ☐ M	2 52 F 7	. Age (In yrs. las	st birthday) Yrs.	If Under Months	1 Year Deys	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, May 10		9. Birthp Coun	lece (State or Foreign try) MD
2	Usuel Residence of Deceder		10c. City, Town or Location										
the Maryland r 28s-f show notified si	MD 10b. Co	N/A			Balti		Cit	У				'	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
0 8 0	10e. Street and Number 1442 Richa	rdson S	treet	reet 101. Zip Code 21230						1	og. Citizen of Uni		try? States
al, or items 23s zaminer must by Funeral	11. Merital Status 1 Never Married 2	Married	Wes Deced Armed Ford 1 Yes 1 If Yes, Give Yeer or Dat	No No	er in U,S. 13. Was Decedent of Hispenic Origin? (Si If Yes, specify Cuben, Mexican, Puerto 1 □ Yes 2 ☑ ▼ o Specify:					ecify Yes or No- Rican, etc.)		ce - Americ ck, White, y:	
Medical Medical	15. Dec (Specify only h Elementery/Secondary (0-	1	on m <i>pleted)</i> College (1-4		16a. Deced (Give life.	ient's Usua kind of wo DO NOT us	al Occup rk done se retired	ation du <i>ring</i> mos	st of work	ing	16b. Kind of B	usiness/inc	dustry
파크 -	11		0		Restaurant Manager						Fo	od Se	ervice
evar Be	Andrew J. Sikorski Andrew J. Sikorski Mary M. Pocisck												
27 ls	19a. Informant's Name/Rele Joseph M. S		Print)	Son		-				erna Pai			^{Code)} 21146
nument of health	20e. Method of Disposition XXBuriel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) Holy Cross Cemetery May 4, 1999 Baltimore											wn, State Maryland	
te hes been signed by the ettending physician end page 2 should be deteched for use as the buriel-transit and page 2 should be deteched for use as the buriel-transit and page 2 should be deteched for use as the buriel-transit and page 2 should be deteched for use and page 2 should be deteched by Physician/Medical Examiner	23e. Pert1. Enter the disees shock, or heert failure. Immediate Cause (Final diseese or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Part II. Other eignificent cor	6 b c d	SE	Due to (or e	es e consec es e consec es e consec	uenca of): uenca of):						ontribute to	Approximate Interval Between Onset and Death 2 DAYS
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been sign should be leted by										24a. Wes e perform	on eutopsy med?	ev	ere eutopsy findings eilable prior to mpletion of cause deeth?
page 2										1 🗆 Ye	es 212 No	1[Yes 20 No
s certificete director, pag To Be Co	25. Was case referred to me examiner?	dical						26. Plac	e of Deat	h (Check only on	ne)		
this ceral dire	1 ☐ Yes 2 ☐ No	Hosp	oital:		R/Outpatier			4 L N		me 5 Reside			y)
After fune	2 LI MODIGOTIL		8e. Date of (Month)	Injury 2 , Dey Year)	8b. Time o Injury	M	28c. Injur Wor 1 □	yet k? Yes 2□		28d. Describe ho			
within 24 hours effer death. To the Funeral Director After completely filled in by the fune Medical Certification	3 Suicide 6 Co	termined	28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)						28f. Location (Si City or Town		per or Rure	el Route Number,	
within 24 hours efter deatl To the Funeral Director: completely filled in by the Medical Certifficat	29a. Certifier 1 Cer (Check only 2 Med	ifying Physicie Ical Examiner:	n: To the b On the bas end menne	is of examinatio	edge, deeth n end/or in	occurred vestigation	et the tir , in my o	ne, date er pinion, dec	nd pleca, eth occur	end due to the cred et the time, d	euse(s) and mate end placa	enner es s , end due te	tated. the ceuse(s)
withir To th comp	29b. Signeture end title of ca	660	n	MD				e number	000		9d. Date sign		Dey, Year)
	30. Name and address of pa	son who comp	eted cause	of deeth (Item 2	3e) (Type, HWS	Print)	OPK	INS	410	SPITA	L		
State Registrar	31. Dete filed (Month, Dey,)	ear)	32: Rec	gistrar's Signetu	re	b .	20	als)				



4. Deceded by the second action	/11/99 EW			ficate of		Reg. No.		There of the re		
1. Decedent's Name (First, Middle, L GUILLERMINA		IUTORT		2. Date of De Month APRIL	Dey 30, 1999	Yeer	Time of Deeth 4:40AM			
	4h Cibe									
Bradford Oaks N	lursing H	ome			Clinto		Prince	e Georg	e's	
		. Age (In yrs. I	B.A	f Under 1 Year lonths Days	If Under 24 H Hours Mi		th y, Year)	9. Birthplace Country)	(Stete or Foreig	
089-03-2598	1□M 270F	}	30 Yrs.			May 16	, 1918De		n Republ	
Usuel Residence of Decedent 10a, State 10b, County		10c, City	, Town or Locati	ion				10d. i	inside City Limits	
									Yes 2 No	
Maryland Prince	George's		Temple H	10f. Zip Code			10g. Citizen of V		21	
4009 Norcross	Street			207	748		US			
11. Marital Status	12. Wes Deced	ent Ever in U.	S. 13. Was			(Specify Yes or No	-	a - American II	ndian,	
1 ☐ Never Married 2 ☐ Married	Armed Ford	Armed Forces? It Yes, specify Cuben, Mexicar 1 ☐ Yes 2₹☐ No If Yes, Give 1 1 ▼Yes 2 ☐ No Specify:					Specify	ck, White, etc.	PANIC	
3 ☐ Widowed 4 ☒ Divorced	Year or Dat	es:	. 20		opoony.		Specily	, urp	PANIC	
15. Decedent's (Specify only highest g			16a. Decedent	t's Usuel Occup d of work done	eation during most of w d)	orking	16b. Kind of B		ry	
Elementary/Secondary (0-12)	College (1-	lor 5+)			d)			GOVT.		
47 5 11 11 11 11 11 11 11 11 11 11 11 11 1	4+		Secre	tary	40 14-11 - 4-11	//**			culture	
17. Father's Neme (First, Middle, Las UNKNOWN	1)				THOMA	Maiden Sumeme)				
19a. Intorment's Name/Relationship	Stete, Zip Coo	de)								
PRISCILLA R. BROO	80110									
20a. Method of Disposition		Date Date	20c. Location							
1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spec			emetery, cremete PROPOLIT			5-1-99	ALEXANI	DRIA, V	IRGINIA	
21. Signature of Funeral Service Lice			22. N	ame end Addre	ss of FacilityMA	RSHALL'S				
Juaway	CK.B	MAKE				SUITLA				
Immediate Cause (Final disease or condition resulting in death) COMMUNITY ACQUIRED PNEUMONIA Due to (or as a consequence ot):										
Sequentially list conditions. Due to (or as e consequenca of):										
if any, leading to immediate										
Ceuse (Diseese or Injury that Initiated events resulting in death) Last Due to (or es e consequenca of):										
Part II. Other significant conditions	contributing to dea	th but not resu	Iting In the unde	rlying cause giv	ren in Part I.	23b. Did	tobacco use co	ntribute to the	cause of death	
						1 ☐ Yes 2 ☐ No 3 ☐ Probably 👫				
					_	-		1		
						24a. Wes	an eutopsy ormed?	availab	outopsy findings ble prior to	
								of deat	etion of cause th?	
						1 🗆	Yes 2 No	1 □ Ye	s 2 No	
25. Was case referred to medical					26. Plece of D	eath (Check only	one)			
examiner?	Hospital: 1 In	patient 2 🗆	ER/Outpetient	3□ DOA Oth	er: 4 Nursing	Home 5 ☐ Resi	dence 6 □Oth	ner (Specify)		
27. Manner of Deeth 1 ☑Netural 5 ☐ Pending	28e. Dete of (Month)	Injury Day Year)	28b. Time of Injury	28c. Inju			how Injury occur			
2 ☐ Accident investigati	on	Duy 1.03.7			Yes 2 □ No					
3 ☐ Suicide 6 ☐ Could not determine	28e. Place o building	28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify)					Street end Numb wn, Stete)	per or Rural Ro	oute Number,	
	hysictan: To the b miner: On the bas and manne	is of examinet								
29e. Certifier (Check only one) 1				29c. Licens	e number	T	29d. Date signe	d (Month, Dey,	Year)	
	12661		1							
	1000			W /	0406		4/5	0/99		
00 11			00.1.				2			
30. Name end eddress of her of who			23a) (Type, Prin		#207 T	ALDORF,	MD 2060			

Alberta 1987 St. 1887 Level Land . 777 the state of the s

Physician /Medical Examiner certificate be axecuted the buriel-transi Records, P.O. Box 68760, physician

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Funeral

Director

Show

Itam 27 is marked other than "natural", or Items 23a or 28a-f sho other traumstic event, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after. Department of Health and Mentel Hygiene. Important: If them 27 is merked other than "natural", or free any injury or other traumatic event

altimore, Maryland 21215-0020

with the Maryland

deeth

USB BS signed by the e this Aftert ne Hospital or Attantion 24 hours after deeth.

Division of Vital Attanding Physician:

Examiner Physician/Medical þ Completed Be P the funeral Certification:

that Initiated events resulting in death) Last Cor Pulmorale

1 Yes 2 No 27. Manper of Death 1 Natural

5 Pending investigation

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Dete of Injury (Month, Dey Yeer) 28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

2 Accident

3 Suicide

29a. Certifier

edicai

4 Homicide

29c. License number D25062 29d. Date signed (Month, Dey, Year)

ARZI 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

me

750 main stoot, Reintastown, Mel 21136

5-3.1999

GAIZY A. MANKO, HO 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

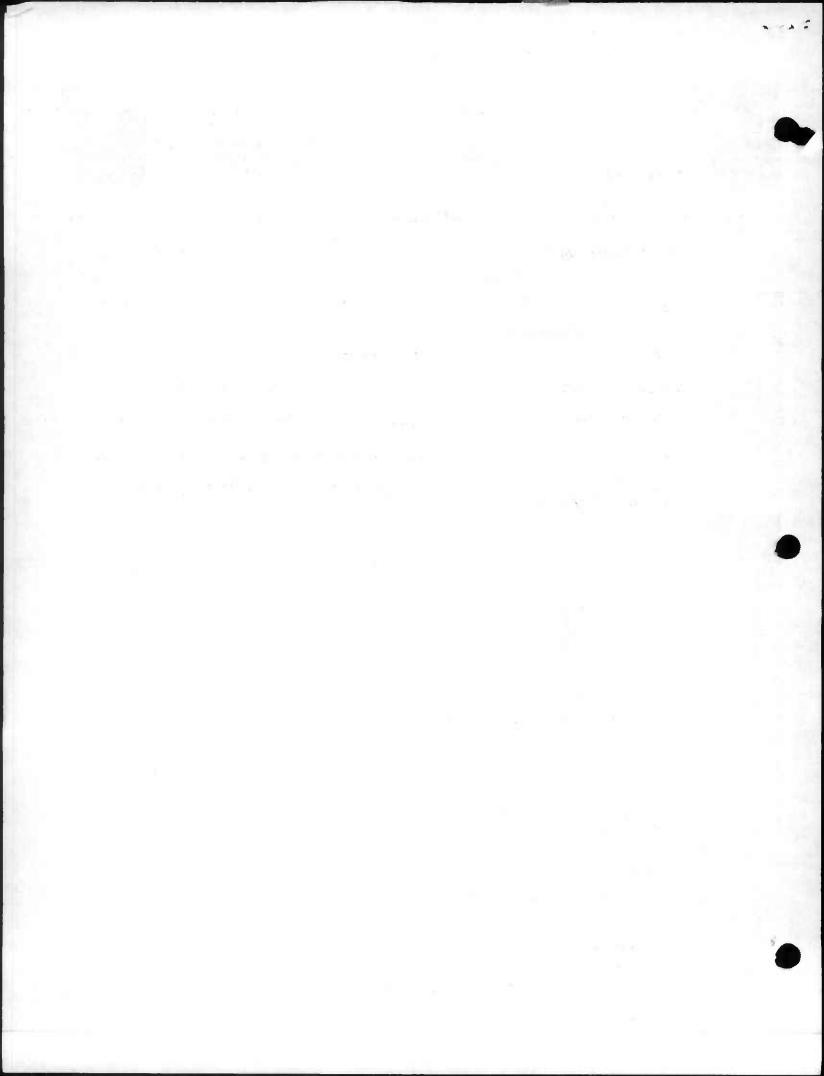
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Physic		1. Decedent's Name (First, ETHEL		st)	ROHR				2. Date of Month	Day	Year 1999	3. Time of Death			
/Medi Examii		4a. Facility Name (If not ins		e street end nu				4b. City, Tov	vn, or Location of Do		County of Death	1 (7,70			
		GEA	169is	MAI	WILTON	j		BAL	TINORE	_ N/	Α				
Funeral Director		5. Social Security Number 213-10-0952		ex □M 2) (1) F	7. Age (In yrs 95	last birthday) Yrs.	if Under 1 Ye Months Da	ys Hours	8. Date of (Month) 03/08/	Birth Dey, Year) 1904	9. Birthy Coul Maryl	place (State or Foreig htry) and			
and W		Usual Residence of Decedor 10a. State 10b. C			10c. C	ty, Town or Lo	cation				T,	Od. Inside City Limit			
r 28a-f show	ctor	MD N/A				timore						1 X Yes 2 □ No			
ceam with the maryland ms 23a or 28a-f show c man be notified at	Funeral Director	10e. Street end Number 5018 Pilgrim	Road				10f. Zip Cod 21214	9		10g. Citizen of Whet Country? United States					
ges 1 and 2 should be filed within 72 hours efter it of Heelih and Mental Hygiene. If item 27 is marked other than "natural", or its or other traumatic event, the Wederal Examine To Be Completed by Ellipse.	by	11. Marital Stetus 1 Never Married 2 3 Widowed 4 Div		12. Was Dec Armed Fo 1 Ues If Yes, Gr Year or D	2 No	.S. 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1. Race- Bleck, 1. Yes 2. № No Specify: Specify:						etc.			
	Completed	15. De (Specify only Elementary/Secondary (0		lucetion de completed) College (1	1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use ret	ne during most ired)	of working	16b. Kind	d of Business/Industry				
	S	6				Sale	Persor			Reta					
	To Be								rs Name (First, Mid herine 0.						
		19a. Informant's Name/Rel Mr. Bosley/fr		Type, Print)								y l and 21030			
		20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) Morel and Memorial Park 5									ation - City or To	Maryland			
Depertment important: any Injury once.		21. Signature of Fuheral Se	rvice Licen	Day	1	5:	Name and Ad 305 Har1	dress of Fecility Ford Roa	Leonard ad, Balti	J. Ruc	Inc. Maryland	1 21214			
e ettending physicien and for use es the buriel-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	{	b	Due to (or as a consec or as a consec or es a consec	uence of):								
ettending p	Physician/Me	d													
een signed by the e	/ Phys	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION								23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow					
s been 2 shou	Completed by								24a. W	es en eutops enformed?	av	ere eutopsy findings ailable prior to mpletion of cause death?			
ate h									11	□Yes 212	No 1	Yes 2□ No			
this certificate ral director, peg	Be c	25. Was cese referred to m examiner?	-	Hospital:					of Death (Check on						
within 24 hours effer death. To the Funeral Director: After this certific completely filled in by the funeral director,	tion: To		ending vestigation	28a. Date (Mont	npatient 2 ☐ of Injury th, Dey Year)	28b. Time of Injury	28c. Ir	4 E Nur		esidence 6 be how injury		y)			
effer death. Director: Affer d in by the fune	Certification:	3 ☐ Suicide 6 ☐ C	ould not be etermined		of Injury - At h ng, etc. (Speci	ome, farm, str	eet, factory, office		28f. Location (Street end Number or Rurel Route Number, City or Town, State)						
within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	edical C	29a, Certifier (Check only one)	tifying Phy dicai Exam	iner: On the ba	best of my kno asis of examina ner stated.	wledge, death tion and/or In	occurred at the restigation, in m	time, date and y opinion, death	plece, and due to the courred at the time	he cause(s) e ne, date and p	nd menner as s lace, and due to	tated. the cause(s)			
withir To th	M	29b. Signeture end title of c						nse number		29d. Date	signed (Month,	Dey, Year)			
		· aunga	ala	no me	9		0	16619		may	2 7,199	99			
	-	30. Name and eddress of pe	rson who c	ompleted ceus	e of death (Iter	n 23a) /Tumo	Duine)					•			
V		C.VERGARA			20	0 N.	BROADU	my s	T. BAG	TIMOZ	E M	0.21251			

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death 0500A.H Richardson 0. Dominick 04 26 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death St Agnes Baltimore Lane # Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)
3 - 29 - 1986 If Under 1 Year Months Days 9. Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sax 7. Age (In yrs. last birthday) Days 1⊠M 2□ F 3 212.27.6402 Usuel Residence of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Hd NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number St Hanes Lane 28 4.5.4 21207 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White, etc. 1 Never Merried 2 Married Specify: Black 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tite. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Mth grade NA NA NA 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) arles Richardson Sheila Mullen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intermant's Name/Reletionship (Type, Print) Butt Sheila Agnes Ba Ho, Md Cane 20b. Place of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Byriel 2 Cremation 3 Removel from Stele
4 Denetion 5 Other (Specify) 00 dlawn emetery 21. Signature of Funeral Service Ligensee 23a. Pan't Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart tailure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in death) Large Cell Lymphoma Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Due to (or es a consequence of): Pert Ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes case reterred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 CResidence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Metural 1 Yes 2 No

/Medical Examiner Box 68760, physiclen s the burie esn P.O. Division of Vital Records. or Attending Physician: this After 24 hours aftar death.

Funeral Director: A Hospital

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Physician/Medical Examiner

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Certification: To Be

Medical

Funeral

Director

Pages 1 and 2 should be filed within 72 hours efter deeth with and Mental Hygiaes. In the first prevent and a state of the

Physician

21215-0020

Baltimore, Maryland

5 Pending investigation

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

29c. License number

IL MODSU, MD

D005 3119

29d. Date signed (Month, Day, Year)

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

Colleen McDonoush, M.D.; 600 N. Wolfe St, Baltimore, M.D. 31. Data filed (Month, Day, Year)

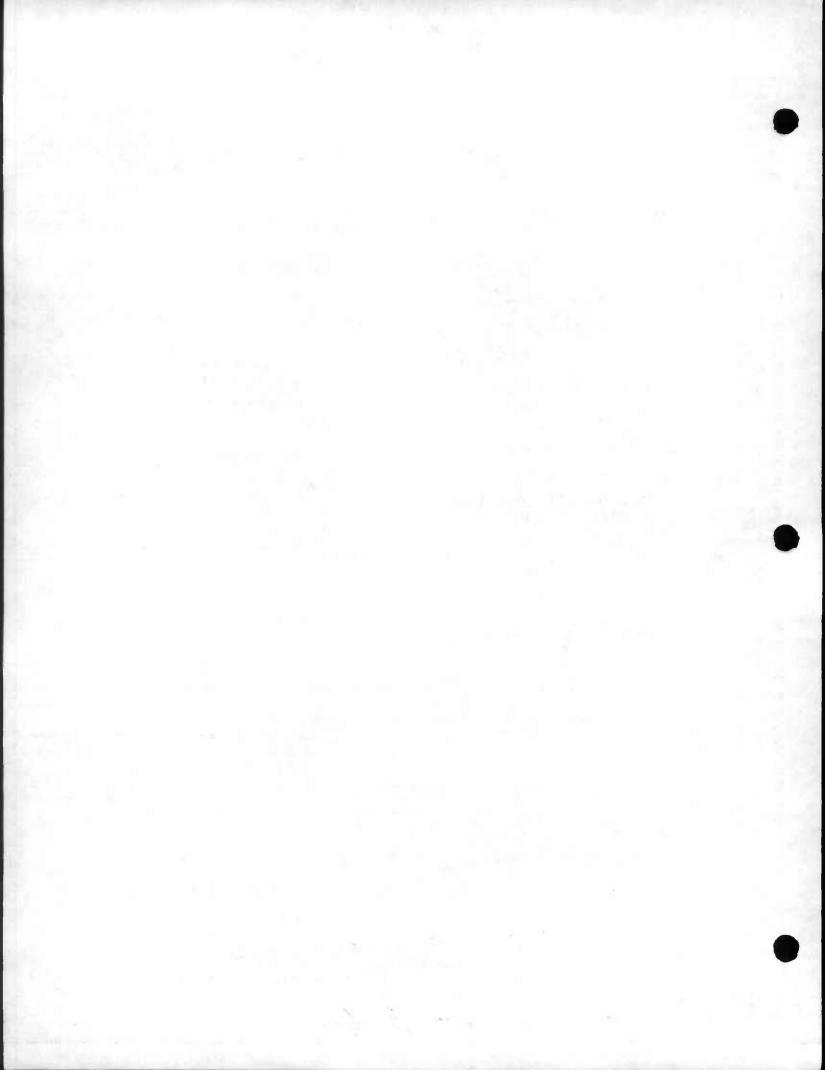
State Registrar

within 2 the th

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6 Could not be determined



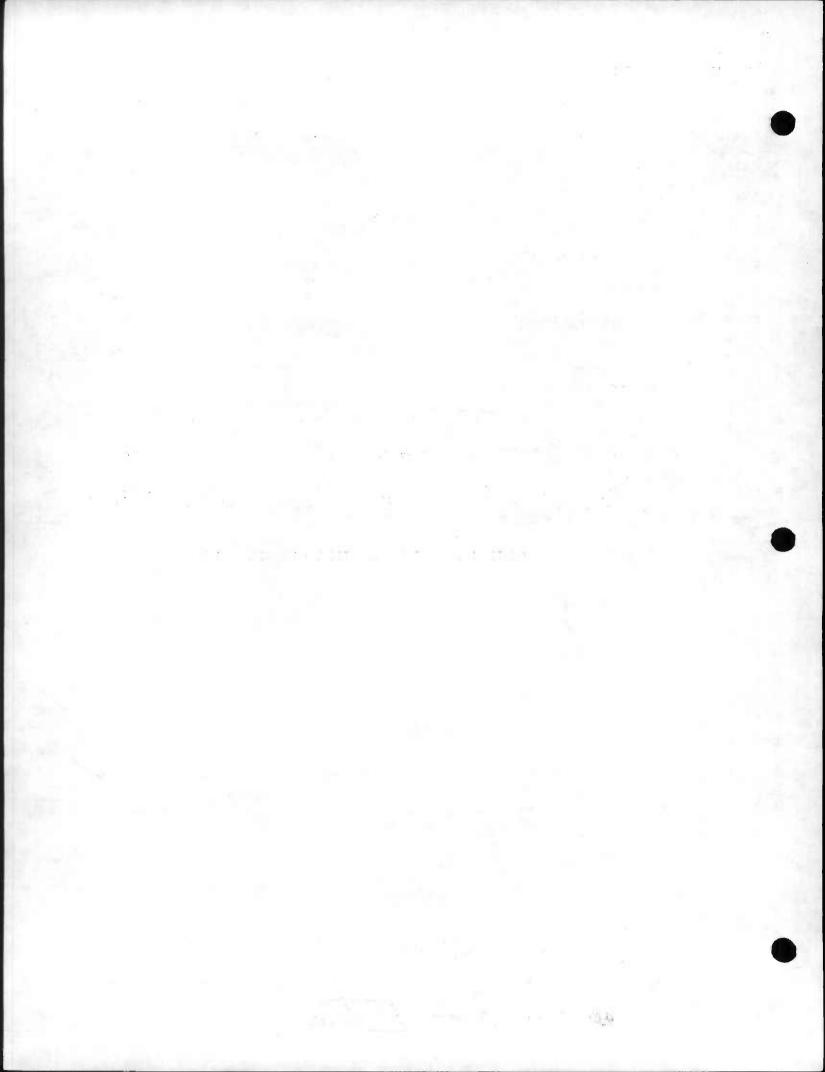


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MARTIN E				_	rtment of H		and Me	ental Hy	giene	1 4	201
SYNDER ITEM	1. Decedent's Name (First, Middle		3-99 WR.	Cen	tificate of	Death		2. Date of De	Reg. No.		3. Time of Death
Physician								Month	Dey Year 30, 1999		06:30 AM
/Medical Examiner	4a Facility Name (If not institution 1454 RIVERSIDE	n, give street and number	7)			4b. City, Too BALTI	wn, or Loc	ation of Deat			AM
Funeral Director	5. Social Security Number 219-68-1619 6. Sex 7. Age (In yrs. last birthday) If Und Month										lece (Stete or Foreign try) and
2	Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location										
with the Marylan a or 28a-f show be notified at										10	0d. Inside City Limits 1 √ Yes 2 No
vith the Ma to 28a-f e be notified Director	10e. Street and Number	11/4	1	атсии	10f. Zip Code				10g. Citizen of \	What Count	Λ
3 a or		de Ave.			212	230			USA		
5-0020 72 hours after deeth with the Maryland natural; or flams 23s or 28s-4 show stell Esaminar must be notified at stell by Funeral Director	11. Marital Stetus 1 Never Merried 2 ☐ Marital 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 5	? No		'as Decedent of H Yes, specify Cub	lispanic Orig an, Mexican	gin? (Spec , Puerto P	cify Yes or No lican, etc.)	14. Red Bled	a - America ck, White, e v: whit	etc.
Maryland 21215-0020 d 2 should be filed within 72 hours at th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Essen To Be Completed by F	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed) College (1-4or		(Give k	ont's Usual Occup ind of work done O NOT use retired Setter	during most	of workin	g	16b. Kind of B		
yland 2 ould be filed Mental Hygical micrael Control To Be Co	17. Father's Name (First, Middle,		(First, Middle	Maiden Sumen		· A					
Maryla d 2 should th and Men 7 is marks traumatic	19a. Informent's Neme/Reletions	ship (Type, Print)		19b. Mailing	Address (Street	and Numbe	r or Rural	Route Numb	er, City or Town,	State, Zip	Code)
	William W Snyo	der Jr. (Fat			Riversid	le Ave	., Ba				
Baitimore, permit. Peges 1 an Inportant: If hen a Important: If hen a any Injury or other ones.	20a. Method of Disposition 1 Burial 2 Cremetion 4 Donation 5 Other (S		cem	etery, crem-	ition (Name of atory or other pla nt Cemet		5,	Date /3/99	Baltimo		
Bail Permit Depart Import any Inj ence.	21. Signature of Fundral Service	Ce Y/a	l-	Me	Name and Addre CCully-P 30 E. Fo	olyni	ak Fu	neral Baltimo	Home P.	A. 2123	80
Physician /Medical Examiner	23a. Perf. Effer the disease, or shock, or heart taiture. List Immediate Cause (Final disease or condition resulting in death)	e. HYPERTENS	line.	Do not ente	r the mode of dyir	ng, such es	cardiac or	respiretory e	rrest,		Approximate Interval Between Onset end Death
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O & \$ 50 \$	Part II. Other significant condition	ons contributing to death	erlying cause given in Part I. 23b				b. Did tobacco use contribute to the cause of death?				
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= F # & O	25. Was case referred to medica					00 01	of Dooth	16		18	Yes 2 No
	examiner?	Hospital:	ient 2 ER	/Outpatient	3 DOA Oth	ner-		(Check only only only only only only only only	denca 8 🗆 Oth	er (Specify	1)
O f 5 7	27. Manner of Death 1 Netural 5 Pendin 2 Accident investig		ury ay Year) 28	b. Time of Injury	28c. Injul Woo		2		how injury occur		
Division of attending P as after deeth. In Director: After tied in by the funeral Certification:	3 Suicide 6 Could determ	ined 289. Placa of Ir	njury - At home vtc. (Specify)	, farm, stre	et, factory, office		2	Bf. Location (: City or To	Street and Numb vn, Stete)	per or Rure	Route Number,
ne Hospi n 24 hou ne Funer pletsly fill edical	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the best Examiner: On the basis of and manner s	of examination	dge, death of and/or inve	occurred et the tir estigation, in my o	me, date end opinion, deat	d placa, er th occurre	nd due to the d et the time,	cause(s) end mo date end pleca,	enner es sta and due to	eted. the cause(s)
withi To the Com	29b. Signature and title of eartifie	atane	M	. A.	29c. Licens				29d. Date signe APRIL 30		
State	30. Name and fidniss of person 31. Date filed (Month, Day, Year)	estane		111 Pe	rint) enn Stre	et, Ba	altim	ore, M	aryland	2120	1
Registrar	MAY 0	NE	yeva	3.	Spain	de					

DHMH 16 Rev 6/95



Gilchrist Center Towson Baltimore Co. 8. Date of Birth (Month, Day, Year) AUGUST 27, 1933 5. Sociel Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign **Funeral** Months Days Hours 1□ M 20XF Winston-Salem, N.C. 214-30-0191 65 **Director** Usuei Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2X No Maryland Howard Co. Woodstock Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? filed within 72 hours after death with Hygiene. ther than "natural", or items 23a or 10600 Davis Ave. 21163 United States of America 14. Race - American Indian Black, Whita, atc. 12. Wes Decadent Evar in U,S. Armed Forcas? Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 11 Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yas, Giva 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Summer Bowling Tour Director Bowling n/a permit. Peges 1 and 2 should be file Department of Health end Mental Hy Important: If Nem 27 is marked other any Injury or other traumetic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Ethel Wilson Melvin Dorsett 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Mr. Rocco Sisto (Husband) 10600 Davis Ave. Woodstock, Maryland 21163 Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Othar (Specify) Dulaney Valley Memorial Gardens 5/01/1999 Timonium, Maryland 22. Name end Address of Facility Ruck Towson Funeral Home, Inc. 21, Signature of Familia Service Licens 1050 York Rd. Towson, Md. 21204 plications that dused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, ans Approximata Intervel Between Onset end Deeth 23a, Part1, Enter the diseas **Physician** Immediate Ceuse (Finel disease or condition resulting in death) nwedical Lon CAncer of years Examiner Due to (or es e consequence of) Physician/Medical Examiner attending physicien end for use as the bunel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or es e consequence of) The law requires that the deeth certificate be Sisto, nancy Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of deeth? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings availabla prior to completion of ceuse of deeth? 24a. Was en eutopsy performed? Completed peen After this certificate hes 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician:

1. Decedent's Name (First, Middle, Last)

4a Facility Nama (If not Institution, give street and number)

Nancy Carolynn Sisto

Physician

Examiner

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5

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1801

/Medical

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2. Dete of Death

Month

April

4b. City, Town, or Location of Deeth

Dev

1999

4c. County of Deeth

28,

3. Tima of Death

7:40 AM

eral Director: After this filled in by the funeral

death.

within 24 hours

State Registrar

Be

2

Certification:

edical

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not be

1 Yes 2 No

27. Manner of Deeth

1 Naturel

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certif

31. Date filed (Month, Dey, Yally)

Hospital: 1 ☐ Inpatient

tem 23e) (Type, Print)

2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

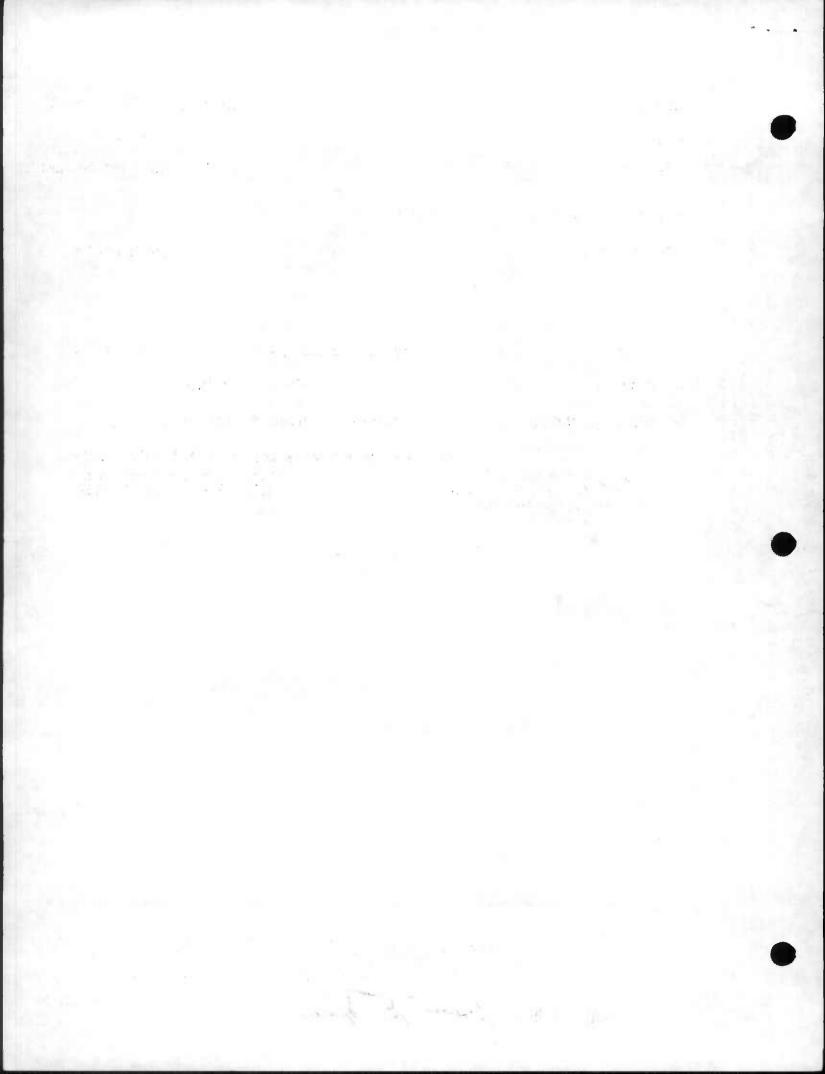
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the or Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

N. Chorles St.

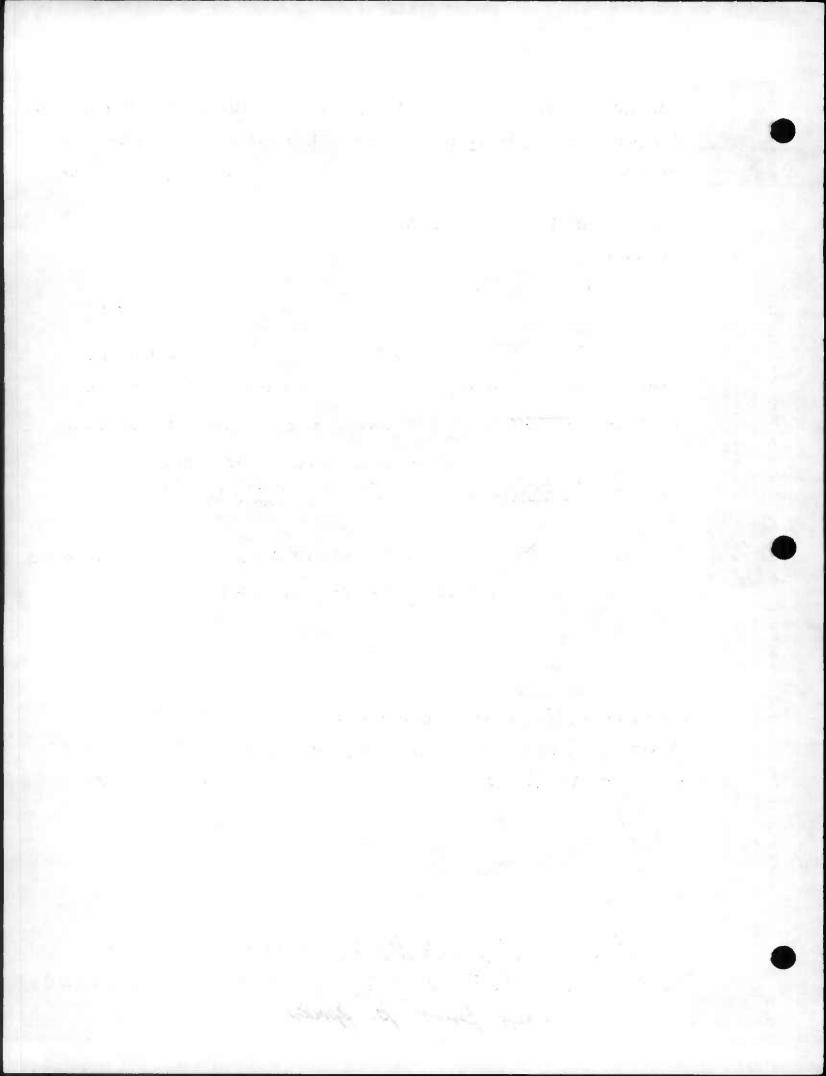
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					,	Cei	tificate of	Death		Reg. No.				
		1. Decedent's Nem	ne (First, Middle, La	st)					2. Dete of De	eth	Van	3. Time of Death		
Physic /Medi		Rober	rt 1	3yron	S	hiple	y, Jr		April	29 19	799	11:02 A.M		
Exami				a street and number)			4b. City, Town, or		4c. County	of Deeth			
/		Frankl	in Squa	ire Hos.	nita	1 Cen	ter	Kosea	dale	Bal	tim	ore		
Funeral		5. Social Security I	Number 6. S	Sex 7. A	ge (In yrs.	lest birthday)	If Under 1 Yea Months Deys			th Year)	9. Birthp	lece (Stete or Foreign		
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oth with the Maryland 23s or 28s-f show	70	10a. State 10b. County 10c. City, Town or Location						on 10d. Inside City Limits 1 ☐ Yes 2 🗓 No						
he M	ecto	Md .	Balti	more	Per	ry Hal	1		10g. Citizen of What Country?					
Alth Page	D						10f. Zip Coda				Auer Conu	try r		
234	erai	5 Harebel	LI Ct.	40 Was Dasadan	From In 11	10 101	2123		Consider Van or No	USA	e - Amaric	an Indian		
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "neturel", or items 23a or 28e-f show say hijury or other treumetic event, the Modical Examinar must be notified at another.	Completed by Funeral Director	11. Marital Stetus 1 □ Navar Man 3 □ Widowed	ried 2 Married 4 □ Divorced	12. Wes Decedan Armed Forcas 1 Yes 2 H If Yes, Giva Yeer or Detes:	?		f Yas, specify Cu	Hispanic Origin? (S ban, Mexicen, Puer Specify:	to Rican, etc.)	etc.				
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D High	BeC	17. Father's Nema	(First, Middle, Last,					18. Mother's Na	me (First, Middle,					
laryland 212 2 should be filed with and Mental Hygiene. Is marked other than	ToB	Robert	Byron	Shi	pley,	Sr.		Margare	et 1	Elizabet	h	Leizure		
Maryland d 2 should be file th and Mental Hy 77 le marked oth treumatic event	-	19e. Informent's N	ame/Reletionship (Type, Print)		19b. Mailir	ng Address (Street	et end Number or R	ural Route Numb	er, City or Town,	Stete, Zip	Code)		
e, Min 1 end 2 Health a em 27 le		Mrs. Dor:	is Shiple	v/wife		4605	Horizon	Cr. Apt.	4 Pikes	sville	Md '	21208		
S 1 6 A B B B B B B B B B B B B B B B B B B		20e. Method of Dis	position			Plece of Dispo	sition (Name of netory or other pi		Dete	20c. Location -				
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Baltimore, permit. Pages 1 el Department of Hea Important: If Item eny Injury or othe ence.			united Supriced-ion		пт.	22	Name and Add	Corp.	5/1/99	Towson,	Ma.			
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		220 Bart Enter	the disappe or com	aliantians that source	d the deet	h Do not ont	050 York	Rd. Tows	son, Md.	21204		Approximate		
		shock, or hea	art failure. List only	plications that ceuse one cause on eech								Interval Between Onsat and Death		
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Examiner		Immadiate Cause (Final disease or condition resulting in deeth) a. Myocardial Infarction Due to (or es e consequence of): b. Coronary Artery Disease										12 Hours		
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Signe Signe Signe	by	00.0						1			045 141	Albania din din di		
Vital Records, P.O. Box 68760 idlan: The law requires that the deeth certificate be certificate has been signed by the attending physicial rector, page 2 should be detached for use as the bur	Completed	Aart	ic 5+	enos	. 21	Co	2005	+ive		en eutopsy ormed?	av	ere eutopsy findings aileble prior to impletion of ceuse		
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of Vita Physician: this certific	To	1 Yes 2	No	Hospital: 1 Inpat	ient 2	ER/Outpetier	I 3 DOA	ther: 4 - Nursing I	Home 5 ☐ Rasi	dence 6 Oth	ar (Specif	y)		
g Physical distribution		27. Mannar of Dae		28a. Dete of inj (Month, D	ury ev Year)	28b. Time of Injury	28c. Inj	ury at	28d. Dascribe	how injury occur	red			
VISION Attending or death. ector: After by the fune	atio	1 Natural 2 Accident	5 Pending investigation)	oy . our,	i i i i i i i i i i i i i i i i i i i		☐Yes 2☐No						
Division of Attending after death. Director: After d in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	28a. Place of Ir building, e	njury - At h etc. <i>(Speci</i> l	ome, farm, str	eet, factory, office	Э	28f. Location (Straet end Number or Rural Route Number, City or Town, State)					
Division of Vital Rewitting the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai C	29a. Certifier (Check only one)	12 Cartifying Ph	ysician: To the best ninar: On the bests end manner s	of examina	owledge, death ation end/or in	n occurred et the restigetion, in my	time, dete end plece opinion, deeth occi	e, and due to the urred et the time,	ceuse(s) end me date end plece,	enner as s	teted. the ceuse(s)		
o the	N	29b. Signeture end	title of certifier				29c. Licer	nse number		29d. Date signe	d (Month,	Day, Year)		
F 3 F Ö		1/	//	n f	41	10 KI	101	12719	27	4/29	199			
6		20 North and Col	words		feel		Brint)	101.		1,00	/			
	1	SU. INAMIO AND GOOD	On Colo	completed ceuse of	3 MM	D Los	- VI	Square	D. 2' 11	Balli	.00-	Derich		
		31. Dete filed (Mor	oth, Dave Year)	5 32. Regist	raris Sign	ature	VIII	Square	Drive,	וואודות	vois)	Linaino.		
Sta	ite	2 Sto mad (14/0/	V	Oz. Hogis	1	. 40	4 5	2 2 7						

DHMH 16 Rev 6/95



Physician /Medical Examiner

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After this certificate has funaral director, page 2:

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thin 24 hours after de the Funeral Directo impletaly fillad in by the

To the To the To the

i or Attending Physician: after death. Director: After this certifica

The law requiras that the death certificete be executed

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

7 is marked other traumatic event, i

nit. Pages 1 and 2 should be file arm ent of Health and Mental Hy ortant: if item 27 is marked oth injury or other traumatic event

filed within 72 hours efter a Hygiene. other than "natural", or Ital

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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Physician/Medical

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Certification: To

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Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

27. Menpar of Death

1 Naturel 2 Accident

3 Suicide

4 Homicide

5 Pending

24a. Was en eutopsy performad? 1 Yes

24b. Were eutopsy findings availabla prior to completion of cause of death?

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No

Other: 4 Nursing Home SesIdence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Yes 2 🗌 No investigation

6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

115 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and dua to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cegifier

WiDI 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deleterezen 31. Date filed (Month, Day, Year) 32. Registrar's Signatura

State Registrar

DHMH 16 Rev 6/95

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P.O. Box 68760 Division of Vital

physician and s the burial-trensit certificate be executed 93 USB o signed by the e pege 2 s certificate Attanding Physician: this After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the funy

Physician

/Medical

Director

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Completed

Examiner

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after ment of Health end Mentel hygiene.
Int. II Item 7 Is marked other than "natural", or ite iny or other traumals event, The Medical Examinary or other traumals event, The Medical Examinary.

permit. Page Department of Important: If any injury or

Physician /Medical

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Certification:

Baltimore,

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Medical Registra

HYON SED 31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only one)

29b. Signature end title of certifier

M.D.

29c. License number 96712

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Dete signed (Month, Day, Year) 1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Ave Baltimore

21224 MD

32. Registrar's Signature



was the second second

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

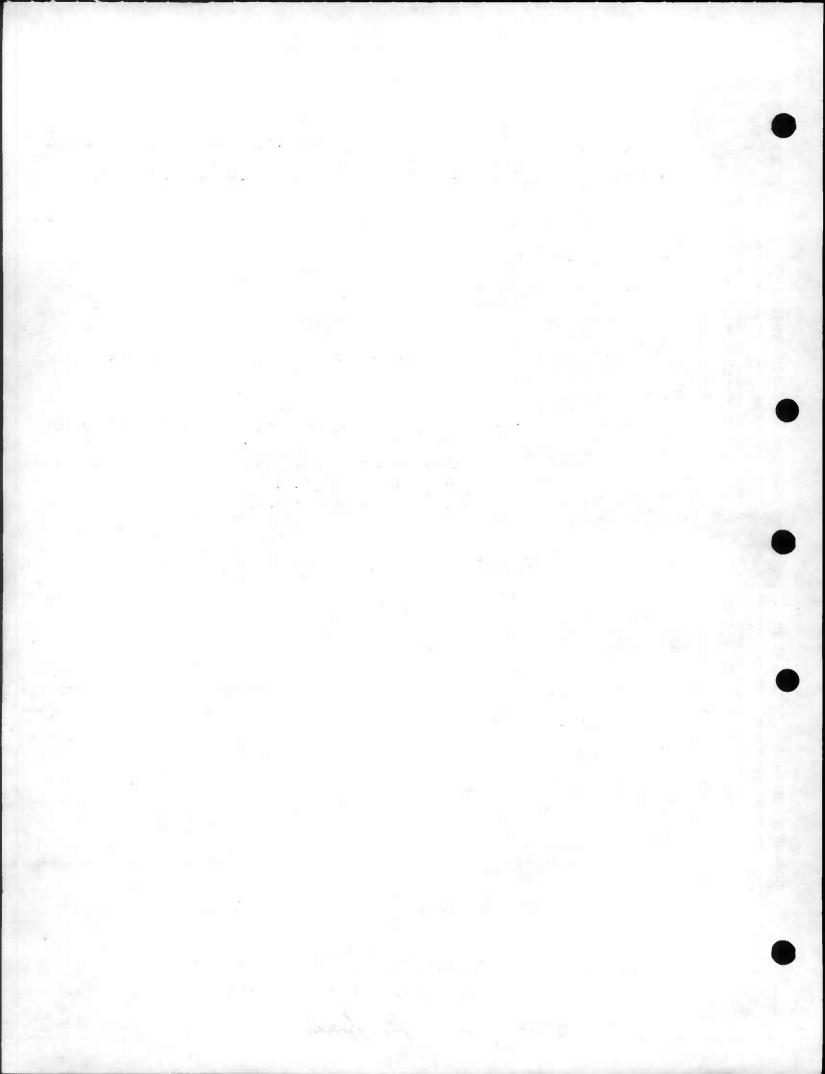
						Certific	ate of	Death		R	eg. No.			
		1. Decedent's Nam	ne (First, Middle, La	est)						2. Dete of Dea	th	V	3. Time of Death	
	ician dical	He	JNZ S	TAND						Month	Dey 30	99	32	
(2)	niner	4a Facility Name (If not institution, giv	ve street and number)			4b. City, To	wn, or Loc	ation of Death	4c. County	of Death		
		606 Wa	allerson	Road				Cator	evil:	10	Ro I	timo		
Funer	al	5. Social Security I	Number 6.5		ge (In yrs. last b	I D PORTY	nder 1 Year	If Under	24 Hrs.	8. Dete of Birth	Dal		elece (State or Foreign etry)	
Direct		212-10-	-6116	1□xM 2□ F	79	Yrs. Mont	ths Days	Hours	Min.	8. Dete of Birth Month, Bey Feb. 9,	1920	Germa	any	
70	-	Usual Residence of	of Decedent											
Maryten -f ahow	tor	MD MD	Balti:	more		nsvill	е					1	0d. Inside City Limits 1 ☐ Yes 2 No	
5-0020 72 hours after death with the Maryland netural; or items 23s or 28s-f ahow death Early and the mortised at	al Director	10e. Street and Nu 606 Wa	allerson	Road		10f.	Zip Code	2122	28	1	U.S.		ntry?	
dead and	Funeral	11. Marital Status		12. Was Decedent	Ever in U,S.	13. Was De	ecedent of	Hispanic Ori	igin? (Spec	cify Yes or No- Rican, etc.)		14. Race - American I Black, White, etc.		
Maryland 21215-0020 of 2 should be filed within 72 hours after th and Mental typiene. 77 le marked other than "natural", or its recumite event, fra Mellan Emmis	0	1 Never Men	ried 2 Merried 4 Divorced	Armed Forces 1 Yes 2 H ff Yes, Give Year or Dates:	No		specify Cub s 2 No			Rican, etc.)	Specify: 16b. Kind of Busines		etc. nite	
72 hours "natural".	Completed		15. Decedent's E		16a	. Decedent's U	Jsual Occu	pation					dustry	
7 4 4	D e	Elementary/Seco	cify only highest gr	ade completed) College (1-4or	5.1	(Give kind of life. DO NO	Work done Tuse retire	during mos d)	t of workin	g				
d 2121	E 0	Libinorital y/300	oridary (0-12)	1		lminist	rator				Marvla:	nd Lo	tterv	
be flied the d other	BeC	17. Father's Name	(First, Middle, Last)				18. Mothe	er's Neme	Maryland Lottery me (First, Middle, Maiden Sumame)				
yian ouid be Mental arked o	0	Freder	ick G. St	aab										
2 should and Men ie marke	-	19e. Informant's N	lame/Relationship (Type, Print)							r. City or Town	State, Zin	Code)	
Marith articular			. Staab (
D THE		20a. Method of Dis			606 Wallerson Road, Catonsville, Maryla						,			
Pages nant of limit: If the		1 D Burial 2	☐ Cremetion 3 ☐	Removel from State		ry, cremetory						-		
timar thank			5 ☐ Other (Special		Loud	on Par	k Cem	etery	15,	/3/99 B	altimon	e, Ma	aryland	
permit. Pages 1 ar Department of Hea Important: if Item 2 eny Injury or other	DUCE	21. Signature of Fi	uneral Service Lice	nsee Bu	4-					zke Fu e, Cato		HOmes, Inc.		
		23a. Pert1. Enter t	the disease, or com	plid flors that cause one cause on each i	d the death. Do	not enter the r	node of dyi	ing, such es	cardiac or	respiretory err	est,		Approximete	
Physicia	n	snock, or nea	art tellure. List only	onercause on each I									Intervel Between Onset and Death	
/Medic		Immediate Cause	(Finel		Vent.	101	AC	tibn.	110	tian		1	14.	
Examin		disease or condition resulting in death)	òn	a	YOMIY	consequence		0		3.0.1			IM	
	ē				Due to (or as a	consequence	of):	ANCI	^			- 1	/M ==	
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end I-tra	Examiner	Sequentially list co if eny, leading to in	onditions, nmediate		Due to (or as a	consequence	of):					1		
deeth certificate be assected estending physician and edior use as the burlet-transit		Cause (Disease or	erlying	C								i		
the sta	edical	that initieted event- resulting in death)			Due to (or as a	consequence	of):							
entiffe ling ;	- 5			d										
eeth cert ettendin	2			U.								1		
de de	Physician	Pert II. Other signi	ficant conditions of	contributing to death b	out not resulting	in the underlying	ng cause gi	ven in Pert I	l.	23b. Dld to	bacco use co	ptribute to	the cause of death	
that the detache detache	Å.									1 D Y	es 21 No	3 Proi	bably 4 Unknow	
s the second	by F						_							
sician: The lew requires that the de certificate has been signed by the rector, page 2 should be detached	8									24a. Wes e	n eutopsy	24b. W	ere eutopsy findings eilable prior to	
lew re	je									perfor	med?	CO	mpletion of cause deeth?	
The lew ata has page 2	Completed									400		1		
ysician: The last contilicate his certificate his director, page		05 114	man mereli								es 2 No	11	Yes 2 No	
Physician: this certific ral director,	Be	25. Wes case reference examiner?		Hospital:			0	hor		(Check only or				
- S # 0	2	1 Yes 2		1 LI Inpati		The same of the sa	DUA	4 LI NU		ne 5 Aeside			y)	
the the	0	27. Manner of Deat 1 Natural	5 Pending	28a. Date of Inju (Month, Da	ay Year) 285.	Time of Injury	28c. Inju Wo			8d. Describe h	ow injury occur	red		
Attending or deeth. octor: Afte	Sat	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes						Yes 2	No					
or Attending after deeth. Director: Afte	Ě	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)						2	8f. Location (Since City or Town		ber or Rura	al Route Number,		
2 4 2 4	Certification:													
To the Hospital or Attending Physical Within 24 hours after deeth. To the Funarel Director: After this completely filled in by the funeral		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end pix and manner stated.							d place, e	ace, end due to the ceuse(s) end menner es steted. ccurred et the time, dete end plece, and due to the ceuse(s)				
ithin of the on the	M	29b. Signeture and	title of certifier	- To The state of		1	29c. Licen:	se number		2	9d. Date signe	d (Month	Dev. Year)	
5 1 5 0 O			100	· ARR	10		7	Tan			1			
			m	and some			T) 10			Mar	130	71	
10		30. Neme and eddr	ress of person who	completed cause of c	death (Item 23a)	(Type, Print)	RAY	Moni	O O	Brhr	MIN.D.			
		141	3/4n	T /1/00	MICH	21	1,0	1 011	///	4 210	<i>I</i>			
5	State	31. Date filed (Mon			rar's Signature									
Regi	strar	MA	y 3 1999	y _ ner	a B	· do	ach	/						

XIR, Dorothy	, Maryland 21215-0
SEBC	Baltimore
4	P.O. Box 68760,

DOROTH	(First, Middle, Las		/99 AH	COIL	ficate of	- 00111	2. Date of De		V	3. Time of Death
		HELEN		S	SEBOUR		Month	Day	Yaqq	9:37 A.M.
Franklin	- 1	tosottal (anter			4b. City, Town, or L Rosadala			of Death	,
5. Social Security Num	mber 6. Se	7. A	ge (In yrs. las		If Under 1 Year	If Under 24 Hrs.				ace (State or Foreign
3-30-9958		1□ M ¾ x F 78		Yrs. Months Days		Hours Min.	Sept.	th Ye 1920	M	aryland
Jsual Residence of Do Oa. State 1	Decedent 10b. County		10c. City,	Town or Loca	tion				10	d. Inside City Limits
MD	Baltimo	re	Ros	sedale						1 Yes 2 No
e. Street and Numb					10f. Zip Code			10g. Citizen of V		
	leigh Ro	ad Unit H		12 Wa	21236	Ilspanic Origin? (S	acify Yas or N	United S	State:	
Marital Status Navar Married Widowed 4		Armed Forces 1 Yes If Yes, Give Year or Datas:	? [No	HY	as, specify Cube	Specify:	Rican, etc.)		k, White, e	itc.
(Specify	5. Decedent's Edit only highest grad	ucation de completed)	16a. Decedent's Usual Occupatio (Give kind of work dona dun life. DO NOT use retired)			ation during most of wor	king	16b. Kind of Bu	usiness/Ind	ustry
Elementary/Second		College (1-4or	5+)		NOT use retired MAKER	a)		OWN H	OME	
7. Father's Name (Fi	irst, Middle, Last)					18. Mother's Nam	ne (First, Middle			
Howard		Fish				RESA		nter1		
19a. Informant's Nam Mrs. Joyo					Road Ba					
20a. Method of Dispos		, 4448.1201	20b. Pla	ce of Disposit			Date	20c. Location -		
	Cremation 3 □I	Removal from State)				. Grdns.	05/05/99	Timon	ium, 1	Maryland
21. Signature/of Fune	eral Service Licent	Stephen I). Cost	er 22.1	Name and Addre	ss of FaciliRuck	Towson	Tunera	1 Hom	e, Inc.
Sten	Kus	Cut	2		0 York			Maryland	2120	4
23a. Part1. Enter the shock, or heart f	disease, or comp failure. List only o	plications that ceuse one cause on each	ad tha daath. line.	Do not enter	tha mode of dyir	ng, such as cardiac	or respiratory	arrast,		Approximata Intervat Between Onset and Death
Immediate Cause (Fir	inal	Hypote	nsion						1	+ Hours
disease or condition resulting in death)		a. TIPOTE		as a conseque	ence of):				1	1 1104.3
		b. Myocar	dia Tr	1						
		p. IIIAACA		Harctic						
sequentially list cond any, leading to imm ause. Enter Underly	ditions, nediate	0 0		Harchi	enca of):	totic				
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art II. Other significa Chronic Ot 5. Was case referred examiner? 1 Yes 20 No. 7. Manner of Death 1 Natural	ant conditions co	c. Small d	Due to (or a Cell Car Due to (or a but not rasult	as a conseque	erlying cause gives a local series of the se	ven in Part I. 26. Place of Dea	24a. Wa peri	Yes 2 No s an autopsy ormed? Yes 2 MNo one)	3 Prob	eably 4 Unknown ore autopsy findings aliabla prior to appletion of cause death? Yes 2 No
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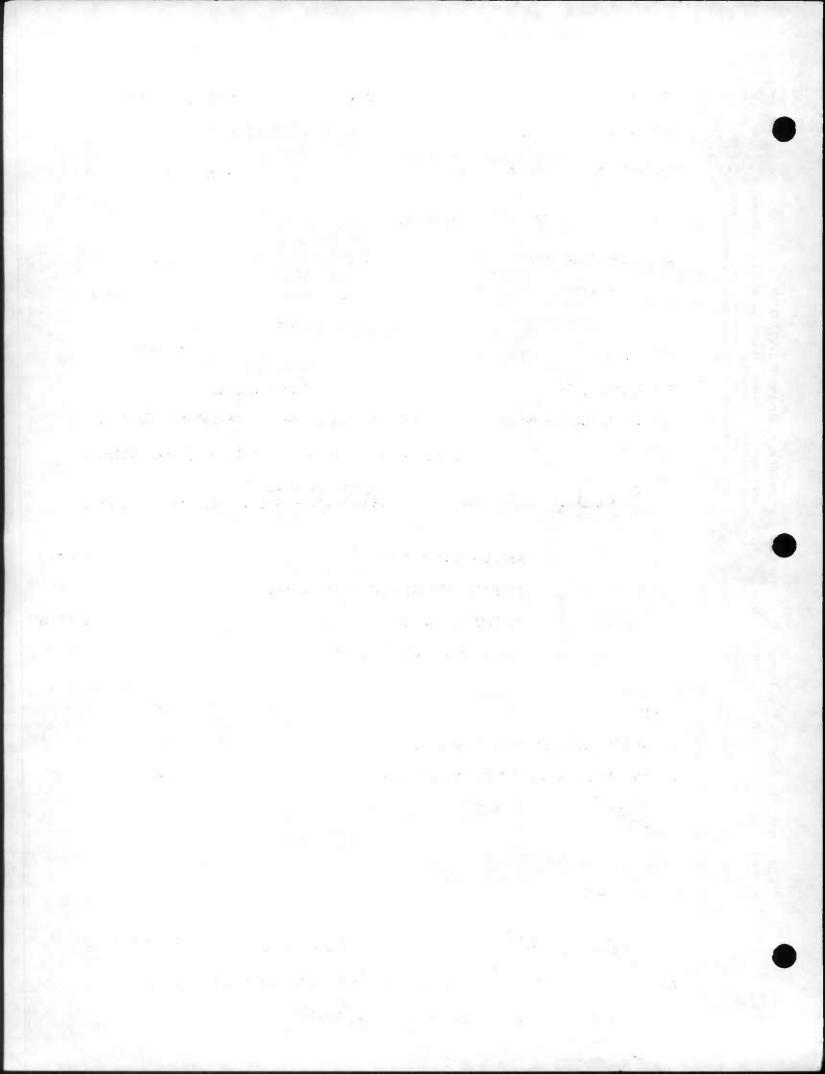
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	1. Decedent's Nar	me (First, Middle, La.	st)						2. Date of De	Reg. No.			3. Time of Death
Physician /Medical Examiner	1	11	N.5.						Month	Day	Ye	ear	9.11.
ledical	mar	Vie.	Jus Ab o	1			th Ch. To		ation of Deat	cd 1	19)	79	1. Lopp
aminer	4a Facility Name	(If not institution, give	e street and jumber	7)						11 4c. C	ounty of i	Death	, /
	Northwe	est Hosp					Rand					imor	
ai	5. Social Security		6ex 7. A	Age (In yrs. la:		Months Days		24 Hrs. Min.	 Date of Bir (Month, Da 	rth sy, Year)	9.	. Birthplac	ce (State or Foreign
or	269-54-	-05/3	UM ZUF	76	Yrs.					8 2		_	L.
ĪΒ	Usual Residence	of Decedent 10b. County		100 City	Town or Loca	ntion				-	-	104	I Indian City I in its
-	Tou. State	Too. County		Too. Oity,	TOWN OF LOCA	BUOTI						100	I. Inside City Limits
Funeral Director	MD		ore Co.	Pik	cesvil	lle							1 ☐ Yes ¾☐No
는	10e. Street and N	umber				10f. Zip Code				10g. Citize	on of Wha	at Country	77
8	1025 B	Flagtree	Lane			21:	208			U	.S. A	Α.	
De l	11. Marital Status		12. Was Deceden Armed Forces	t Ever in U,S	. 13. Wa	as Decedent of	f Hispanic Origin? (Specify uban, Mexican, Puerto Rica		city Yes or No	o- 14	14. Race - American Black, White, et		
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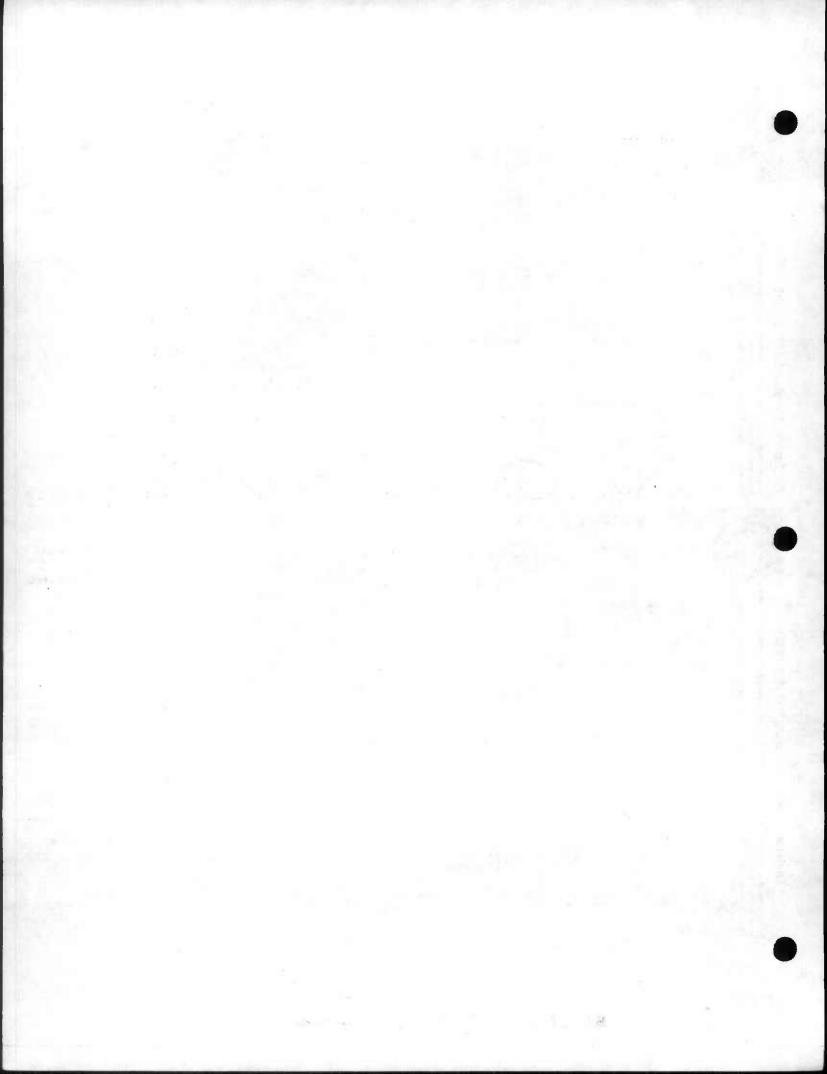
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State of Maryland / Department of Health and Mental Hygiene

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Laineiai	11. Marital Status		12. Was De Armed F	cedent Ever in	U,S. 13	. Was Decede	Becedent of Hispanic Origin? (Sp as, specify Cuban, Mexican, Puarto			ecify Yas or No Rican, etc.)	- 14. Ra	ce - Amari		ın,
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	19a. Informant's Na	me/Ratationship	p (Type, Print)	pe, Print) 19b. Meiling Address (Street and Number or Rural Routs Number, City or T					er, City or Town	n, State, Zij	o Coda)			
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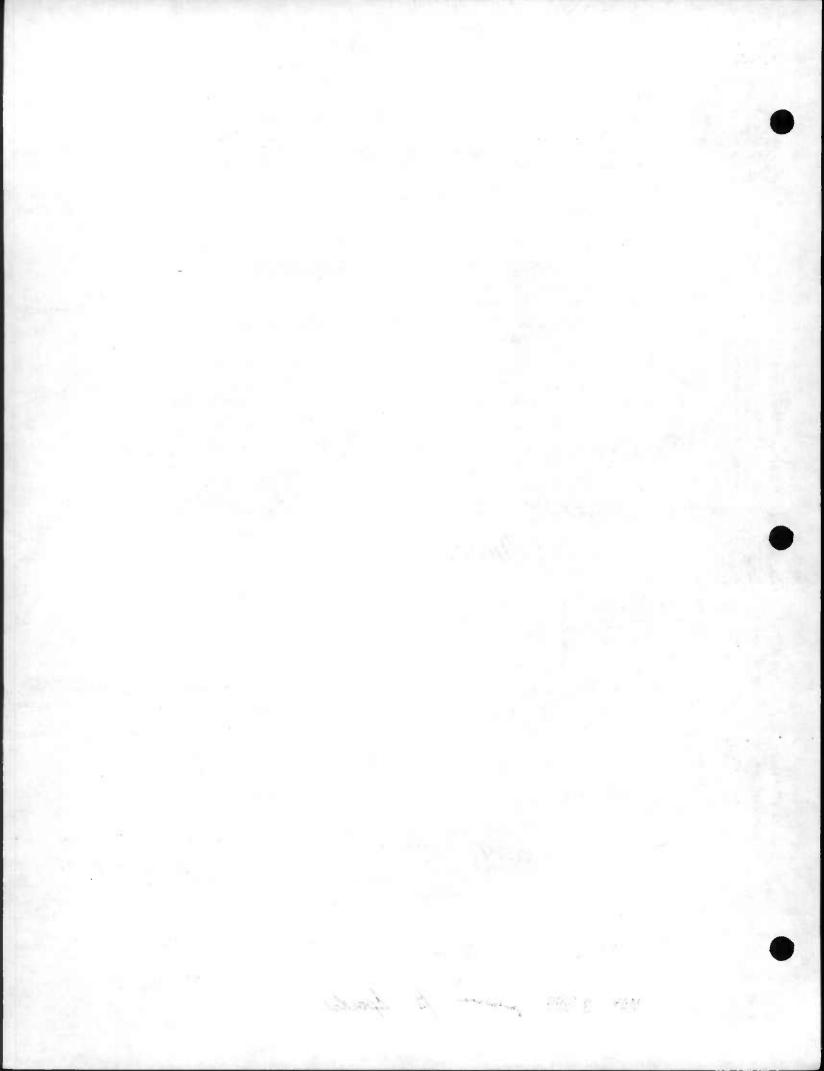


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State of Maryland / Department of Health and Mental Hygiene

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	/Medica Examine	_	4e Facility Neme (lf not institution, g NAI HOSI		nber)					own, or Lo	cation of Deat	h 4c. C	County of Dea	ith
	Funeral Director		5. Social Security N 216-01-		Sex 1 D M 2 F	7. Age (In) 80	yrs. last birt		If Under 1 Yea Months Day		24 Hrs. Min.	8. Dete of Bir Month, Pi	7,191	9. Bi	thplace (State or Foreign ountry) ryland
	Meryland 4 ahow	1	Usuel Residence o 10a. Stata MD	Decedent 10b. County Baltin	ore		City, Town								10d. Inside City Limits 1 ☐ Yas 2 ☐ No
	after deeth with the Merylan or items 23s or 28s-f show caling mast be notified at	al Director	10e. Street and Nu 6143 R	mber legent Pa	rk Road				10f. Zip Code	21228				en of What C	ountry?
020	Marytalia 4 12 13-004 d 2 should be filed within 72 hours the and Mental Hygiene. Tria marked other than 'natural', traumatic avant, the Medical En	11. Maritel Status 1 Never Merr 3 Widowed	ied 2⊠ Married	12. Was Dece Armed For 1 1 Yes If Yes, Give Yeer or Da	ces? 2 No	wii		as Decedent of res, specify Cu			ocify Yes or No Rican, atc.)		Black, Whi	erican Indian, te, etc.	
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pu		17. Father's Nema							18. Moth	er's Name	Name (First, Middle, Maiden Surname)				
ylaı		Royal C	. Tapman							Boel	hm				
Mar		19e. Informent's N			Print) 19b. Mailing Address (Street and Number or Rura										
		Jeannett		(wite)	20			ion (Name of	Park k	toad,	Catons			21228 Town, State	
Baltimore,	nit. Peges 1 er sertment of Hea ortant: If Item 2 Injury or other		1 ☑ Burial 2 4 ☐ Donetion	☐ Cremetion 3 5 ☐ Other (Spec		Stete	ID Vet	y, cremat eran	tory or other po			/5/99			ls, MD
Bal	permit. F Departm Importar any injur		21. Signeture of Fu	Ineral Service Lice	Lemm	er			Name end Add		Wit	zke Fur ue, Cat			, Inc. MD 21228
	Physician /Medical Examiner the burial-transit	Examiner	immediate Ceuse disease or condition resulting in death) Sequentially list confirmed in the cause. Enter Unic Cause. (Disease or Cause, (Disease or Cause, (Disease or Cause, Cause, Cause, Colsease or Cause, (Disease or Ca	in The state of th	• <u>m</u>		o (or as a c	0							Onset end Death
Box 68760,	ficate be physicia ss the but	rnysicianymedical	Cause (Disease or that initiated events resulting in death)		c	Due to	o (or es a c	conseque	nce of):						
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Vital	s certificate director, peg	DO	25. Wes case refer axeminer?	red to medical	11 11				1-		e of Death	(Check only	one)		
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Division	To the Hospital or Attanding Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	27. Menner of Deeth 1							ory, office 28f. Location (Street and Number or hard Josep Number, —City of Towns State)						
	To the Hospital within 24 hours or To the Funeral completely filled	29e. Certifier (Check only one) 29e. Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opi and menner steted.							et the time, date end place, end due to the						
	within 2 the comple								29c. License number 29d. Date signed (Month, Day, Year)			th, Day, Year)			
				Chuk ry O.C.M.E.						MA	Y 02,	1999			
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	State Registra		31. Data filed (Mer	Y. Day 3'-199	32 Re	olstrads Si	gnetural	A	porks	/					



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Department of	Health and	Mental	Hygiene .
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				00	ertificate o	or Douter			Reg. No.		
1. Decedent's Name (First, Middle, Last) CLARENCE C. WHETSTONE III 4s Facility Name (If not institution, give street and number) 4b. City, Town,								Dete of Dea Month	Day	Year	3. Time of Death
	C	LARENCE C.	WHETSTONE :	III					28, 199		10:19 A.M
er	1000								,		
			ral St., 1st fl			Balti				/A	
			S. Sex 7. Age (In y	rs. last birthday Yrs.	If Under 1 Y	ear If Under a	Min.	8. Date of Birt (Month, Day	y, Year)	9. Birthp Coun	lace (State or Foreign try)
		3-94-6455 Residence of Decedent	x 3	2 115.				DEC. 1	1,1966	MARY	LAND
	10a. S		10c.	City, Town or L	ocation.					16	0d. Inside City Limits
0	247	ADVI AND	7/7		T. (1) (1) (1)						1∏ Yes 2□ No
Director	-	ARYLAND N	I/A	BA	LTIMORE 10f. Zip Coo	de			10a Citizen of I	Og. Citizen of What Country?	
2		2707 E. FEDERA	AL STREET fire	st floo		213				U.S.A.	
by Funeral	11 14	arital Status	12. Was Decedent Ever in		13. Wes Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl			rity Yes or No		U.S.A. 14. Race - American Indien,	
5	11. M	amai status ☐ Never Married 2 ☐ Married	Armed Forces?	10,0.	If Yes, specify	Cuban, Mexican	, Puerto R	lican, atc.)		Black, White, etc.	
	31	☐ Widowed 4√☐ Divorced	d 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates:		1□ Yes 2√	No Specify:			Specify	Specify: AFRO-AM	
		X 15. Decedent's		16a. Deci	16a. Decedent's Usual Occupation (Give kind of work done during most of work						
Ne C		(Specify only highest	grade completed)	(Giv	(Give kind of work done during most of wor life. DO NOT use retired)			g		Sb. Kind of Business/Industry	
Department of Health and Abrutal Department of Health and Mental Important: if Hen 27 is marked on any injury or other traumatic average of the contraction of the co	Elei	mentary/Secondary (0-12) 12TH	College (1-4or 5+) N/A	WATE	WATER METER INSTALLER				DIII I. O.	T. OF PUBLIC WORKS	
	17. Fa	ther's Name (First, Middle, Li						(First, Middle,	Maiden Sumen	ne)	
	(CLARENCE C. WH	HETSTONE, JR.						URKIN		
	19a. I	Informant's Name/Relationship	p (Type, Print)							, Stete, Zip	Code)
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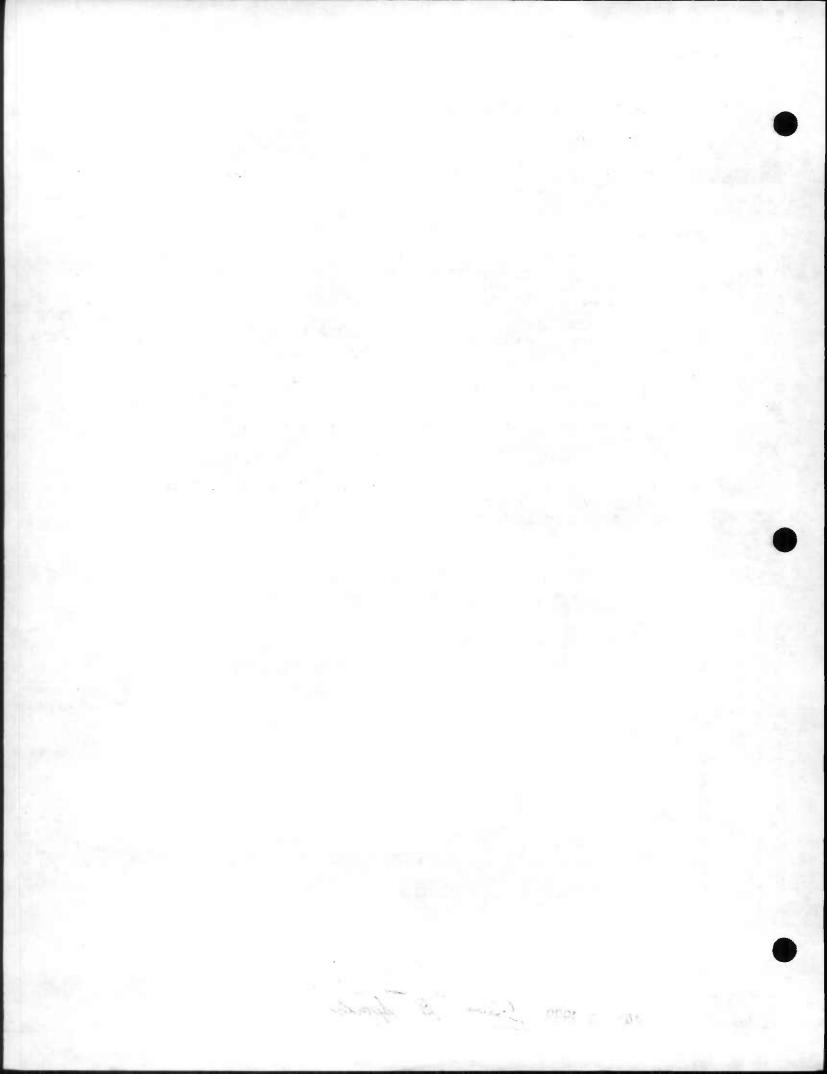
State Registrar Stephen S 31. Date filed (Month, May, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 Radentz

O.C.M.E.

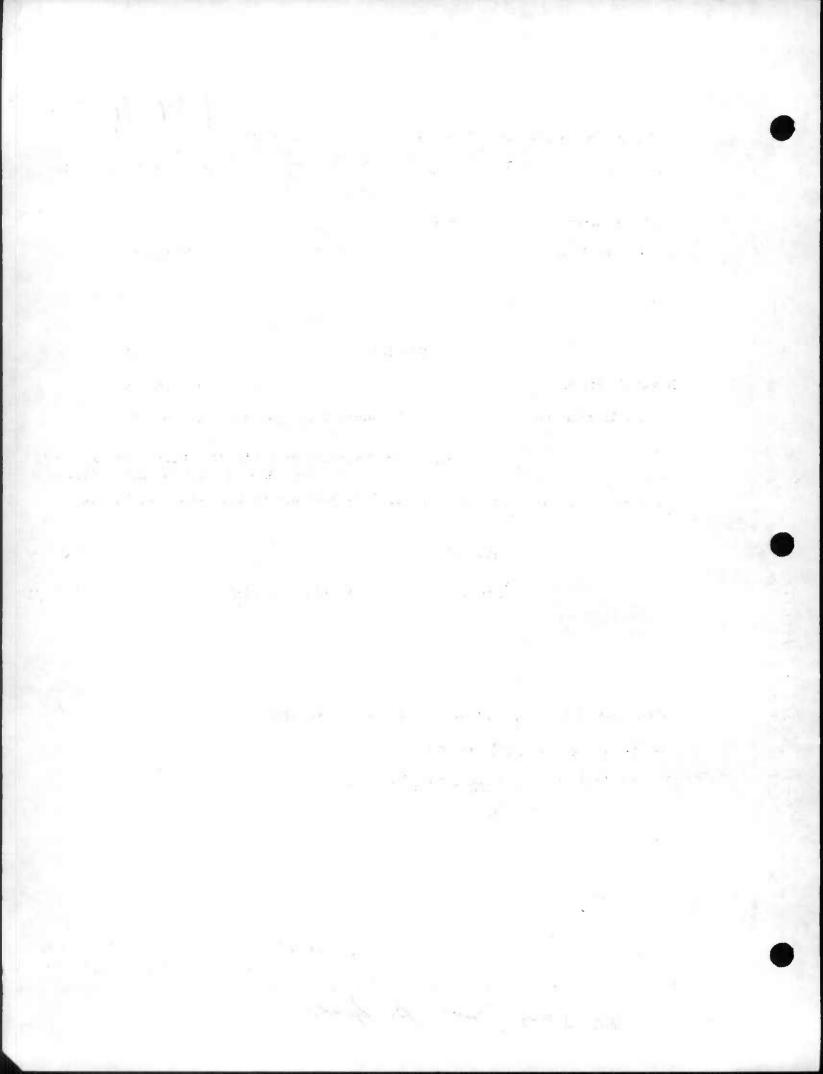
April 29, 1999



oaks

DHMH 16 Ray 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99-2424-510 Certificate of Death 28A-F PER MEO g771 5-4-99 J.A 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Year ROBERT Month Day **Physician** WEEMS JA4 27, APRIL 1999 2029 PM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner I. Date of Birth 1133 N. MONROE STREET BALTIMORE If Under 24 Ars. Ta If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 10 M 20 F 39 214-68-4232 Yrs. Director 16, 1959 Mary Jans Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ehow. to be notified at BALTIMORE LATES 2 No Director larypus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HONDE STREET 21217 1133 USA 238 Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 200 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indien. 11. Meritel Stetus Bleck, White, etc 72 hours after 1 Never Merried 2 Merried "natural", or 1 Yes 2 No Specify: 21215-0020 à 3 ☐ Widowed 4 Divorced Black Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ent Construction Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Operator 12 4BARS permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: if frem 27 te marked other
any Injury or other treument. Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be CALVIN HOWARD WEEMS DELOKED FRANCES 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) N. MONIOS Belhower Many laws 57 FRANCES (VEE'MS 1501 MOTHER 20b. Plece of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, cremetory or other place) 1 Burial 2 Cremetion 3 Removel from State BAL tideorE, Hary lows 5/3 Pathrepal Cemeter 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility (1/1) Taring - Klamis Kineral Home 21. Signeture of Funeral Service Licensii 5240 REISTERSTUN ROPE BOSTSHUE, LLD SIST 23e. Pert1. Enter the diagrae, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finet NARCOTIC AND ALCOHOL INTOXICATION disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner sician and burial-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of): the death certificate be execu Box 68760 physician Physician/Medical the Due to (or es e consequence of): 950 Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were eutopsy findings eveilable prior to 24a. Wes en eutopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical etely filled in by the funeral director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home XXXResidence 6 Other (Specify) XXX es 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Menner of Deeth 28e. Dete of tnjury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Neturel 5 Pending FOUND: 4-27-99 FOUND:8;15M 1 Yes 2 NNo UNKNOWN investigetion 2 Accident 6 X Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1133 N. MONROE ST. FOUND AT HOME 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es steted.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. edical completely (Check only one) To the Vithin 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 29c. License number OCME APRIL 28, 1999

State Registrar

1999

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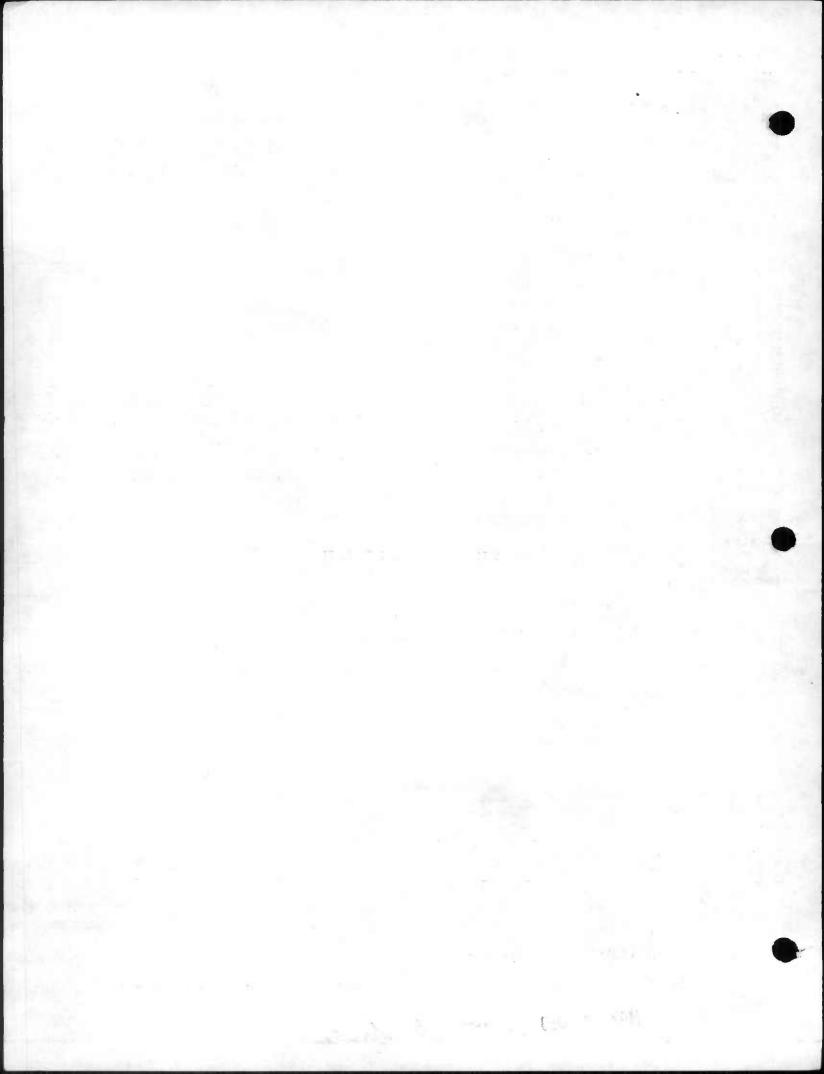
31. Dete filed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. KOpen Mr

32. Registrer's Signeture ORIGINAL

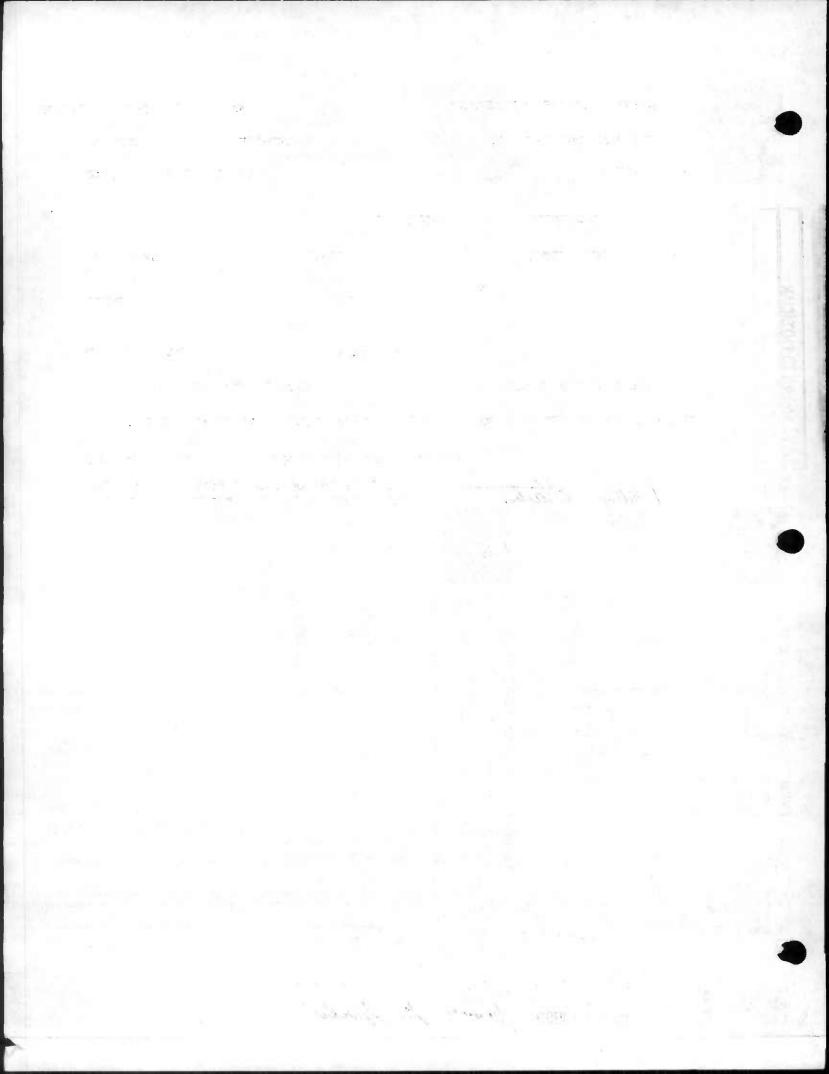
111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Dev Veer OLIVE PAULINE WAWRZYNIAK MAY 1999 11:30AM /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner IVY HALL NURSING HOME BALTIMORE BALTIMORE 5 Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Deys Hours Min. (Month, Dey, Year) 7. Age (In yrs. last birthday) **Funeral** Birthpleca (State or Foreign Country) 1 M 2 TE Deys 79 Yrs. Director 176-12-3784 NOV 28 1919 OHIO Usuel Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show Pages 1 and 2 should be filed within 72 hours after daath with the Ma 1 ☐ Yes 2 No No Director BALTIMORE BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 605 FUSELAGE AVENUE 21221 Funeral USA itams ; 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. the Medical Examiner 1 Never Married 2 Married ò 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 2 Widowed 4 ☐ Divorcad WHITE Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) than Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING FORELADY It of Haalth and North Hyo If item 27 is marked other or other treumatic event, I 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be JAMES FLOYD LOCKE MATTIE MAY BURGESS 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) EDWARD KEITH WAWRZYNIAK, SON 605 FUSELAGE AVENUE, BALTIMORE, MD 21221 Baltimore 20b. Pleca of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete permit Page Department Important: If any injury or RESTHAVEN MEMORIAL GARDEN 5-5 HILLSBORO, OHIO 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature at Funeral Service License 22. Neme end Address of Fecilit STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVENUE, BALTIMORE, MD 21228 736 EDMONDSON AVENUE, BALTIM
23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Betw Onset end Deeth Physician /Medical Immediete Ceuse (Finel 1055 BLE diseese or condition resulting in death) Examiner by lovemie + bylerlarbie The law requires that the death cartificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting In deeth) Lest Due to (or es e consequenca of): ARTBRITIS M/OCU A Box 68760. physician Cell Physician/Medical Due to (or es e consequença of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by the page 2 should be deteched 1 ☑Yes 2 ☐ No 3 Probably 4 Unknown Division of Vital Records, þ Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? this certificate has 1 | Yes 2 | 2 No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di complataly filled Is 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end manner steted. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14221 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) 223 B. Brus 17RO2VI nus 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Kose WHALEN 04 Am Hogelina 4e Fecility Neme (Whot Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Rehab Ellicott Nursing & Howard If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex Birthplece (State or Foreign Country) Months Deys 10 M 20 F Hours 214-16-5929 79 MD Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 1 Yes 2 □ No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 Shepherd House Court 21228 USA 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2K Married Specify: White 1 Yes XX No Specify: 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Rosario Vinci Teresa Gugliuzza 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Stephen Whalen, Jr/ son 6201 Foxhall Farm Road, Baltimore, Md. 21228 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete cemetery, cremetory or other place) 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Lorraine Park 5/3/99 Baltimore, Md 22. Name end Address of Fecility 21. Signeture Funeral Service Licensee Sterling-Ashton-Schwab Funeral Home, Inc 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Zheimer's Vilace Chavanely Immediete Ceuse (Final disease or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditione contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown 24b. Were eutopsy findings evellable prior to completion of ceuse of deeth? 24a. Wes en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. injury et Work? 28d. Describe how Injury occurred 28b. Time of 1. Naturel 2 Accident 5 Pending 1 Yes 2 No investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer)

The law requires that the death certificate be executed P.O. Box 68760 Records, Division of Vital or Attending Physician: after death.

Director: After this certifications To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

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filed within 72 hours after

.. Pages 1 and 2 should be filed v trant of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumatic event, to

permit. Page Department of Important: If any Injury or once.

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State Registrar

31. Date filed (Month, Day, Yeer)

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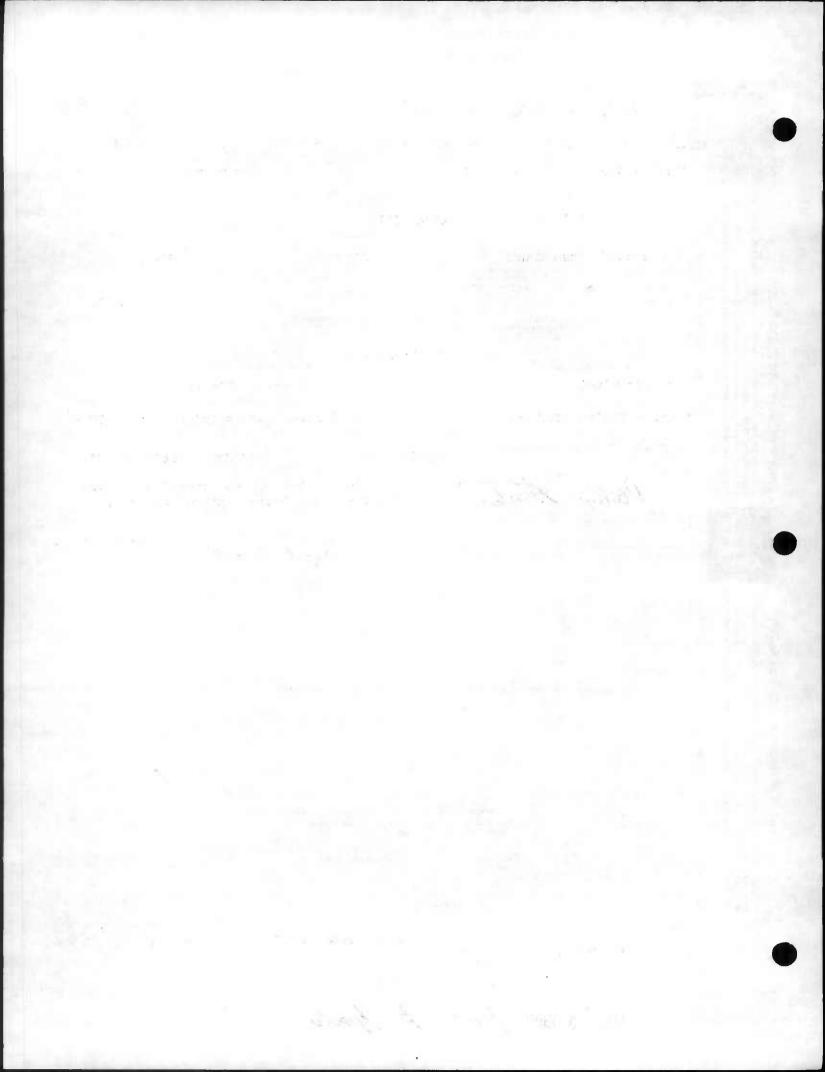
ALEJANORO

30. Neme end eddress of person who completed eause of deeth (Item 23e) (Type, Print)



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Please Type or Print in Black indelible Ink. Assure Ail Copies Are Legible.

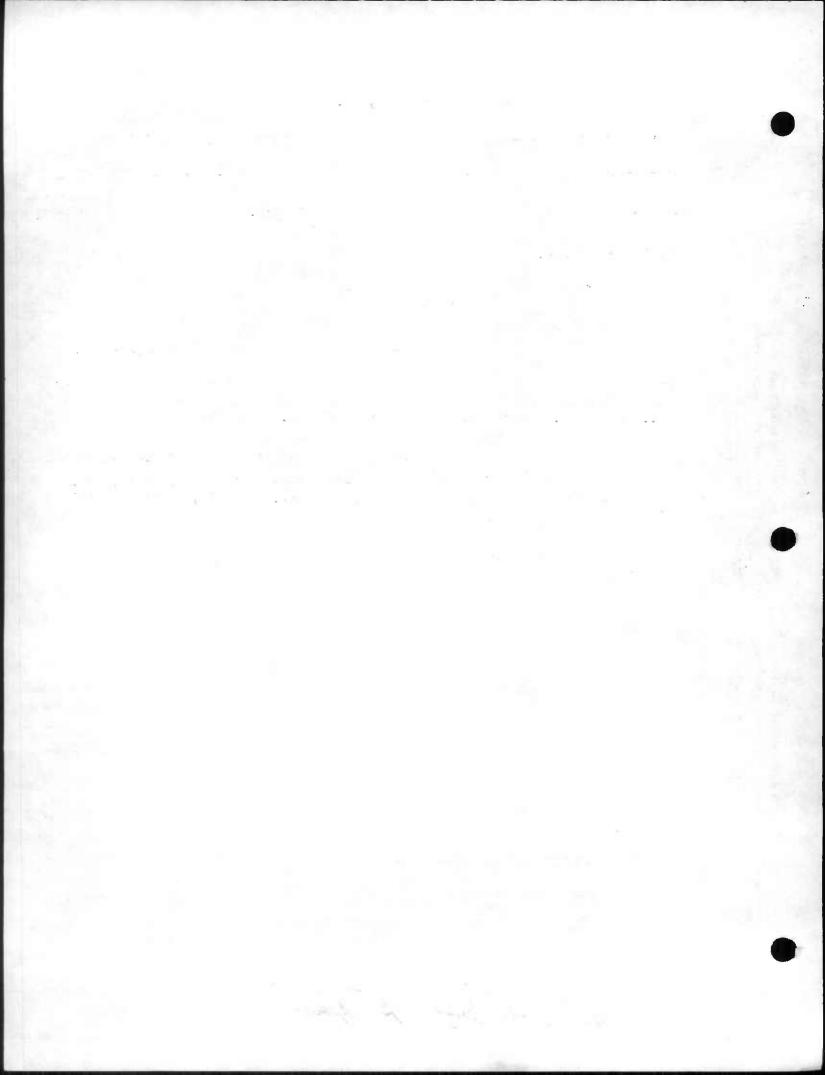
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iner	4a Facility Nama (If no	ot institution, gi	ive street and number)				4b. City, Town, or	Location of Death	4c. County	of Death	
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Dy ruysiciatum	rasulting in death) Las	-	d	ut not resulting	g in tha underlyi	ng causa gi	ven in Part I.	1 □		3 Probably 24b. Wara au	topsy findings prior to on of cause
ey injoicial and	rasulting in death) Las	-	dcontributing to death b	ut not resulting	n tha underlyi	ng causa giv	ren in Part I.	1 □	Yes 2 No an autopsy	3 Probebly 24b. Wara au eveilable completi of death	TOPSY findings oprior to on of cause?
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be completed by Physician/Mi	rasulting in death) Las Part II. Other eignifica	ent conditions of	d		g in the underlying in the und	Ott	26. Place of De	24a. Was perfo	an autopsymmed? Yes 2X No	3 Probably 24b. Wara au eveilable completi of death 1 Yes	topsy findings prior to on of cause?
the property of the party of th	Part II. Other eignifications are saminar? 1 Yas 2 M No 27. Mannar of Death	ant conditions of	Hospital:	int 2□ER/v	Outpatient 3C	I DOA Ott	26. Place of De	24a. Was perfo	an autopsymmed? Yes 2X No	3 Probably 24b. Wara au eveilable completi of death 1 Yes	topsy findings prior to on of cause?
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the property of the party of th	Part II. Other eignification in the state of	ant conditions of to medical	Hospital: 1 Inpatie	int 2□ER/(ny Year) 28t	Outpatient 3 . Time of Injury M	DOA Ott	26. Place of De ner: 4 □ Nursing h ry at rk?	24a. Was perfo	Yes 2 No an autopsymmed? Yes 2 No ona) denca 6 NOth how injury occur Street and Numb	3 Probably 24b. Wara au eveilable complete of death 1 Yes ar (Specify) H ored	4X Unknown topsy findings prior to on of cause ? 2□ No OSPICE
edical Certification: To Be Completed by Physician/Medical	25. Was casa rafarred axaminar? 1 Yas 2 No 27. Mannar of Death 1 Natural 2 Accidant 3 Suicida 4 Homicida	ant conditions of to medical 5 Pending invastigation of Could not be datarmined.	Hospital: 1 ☐ Inpatie 28a. Data of Inju (Month, Da) 28a. Placa of Inju	int 2 ER/inty / 28t / 28	Outpatient 3C. Time of Injury M. farm, streat, far.	DOA Ott	26. Place of De ner: 4 □ Nursing b ny at nk? Yes 2 □ No	24a. Was performed to the control of	Yes 2 No an autopsymmed? Yes 2 No ona) denca 6 Noth how injury occur Street and Numb wn, State) cause(s) and ma	24b. Wara au eveilable complete of death 1 Yes ar (Specity) H ored	topsy findings prior to on of cause? 2 No
Certification: 10 Be Completed by Physician/Me	25. Was casa rafarred axaminar? 1 Yas 2 No 27. Mannar of Death 1 Noticida 4 Homicida	ant conditions of to medical 5 Pending invastigation of Could not be datarmined. **Certifying Pt Medical Examples of the Could not be determined.	Hospital: 1 Inpetie 28a. Data of Inju (Month, Da 28a. Placa of Inju building, etc.) hysician: To the basis of	int 2 ER/inty / 28t / 28	Outpatient 3C. Time of Injury M. farm, streat, far.	DOA Ott	26. Place of De ner: 4 □ Nursing I y at rk? Yes 2 □ No ma, data and place ppinion, death occur	24a. Was performed to the control of	Yes 2 No an autopsymmed? Yes 2 No ona) denca 6 Noth how injury occur Street and Numb wn, State) cause(s) and ma	3 Probably 24b. Wara au eveilable complete of death' 1 Yes ar (Specify) H (red per or Rural Roughanner as stated, and dua to the complete of the second	topsy findings prior to on of cause? 2 No OSDICE ta Number,
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DHMH 16 Rev 6/95

6:10 p.m.

April 27, 1999

Austin Weber



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 5:23 PM 9 SHERI 4c. County of Deeth 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) Baltimore amaritan Hospita A If Under 1 Year | If Under 24 Hrs. . Age (In yrs lest birthdey) Birthplece (State or Foreign Country) 220-12-970 Usuel Residence of Decedent 1 M 2 F Deys Yrs. 10e. State 10b. County 10c. City_Town or Location 10d. Inside City Limits 1 Yes 2 No MOR 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? TUY 2 d 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced AMERICAN 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary ndary (0-12) OMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Print) Gundian 19b. Melling Address (Street end Numb +Morene 20b. Plece 20a. Method of Disposition Durial 2 Cremetion 3 Removel from State 1 Durial 2 Cremetion 3 F 21. Signeture of Funeral Service Licenses 4021217 236 Part1. Enter the disease shock, or heart failure. thet caused the deeth. Do not en Approximete Intervel Between Onset end Death ne cause on each Immediate Ceuse (Finel disease or condition resulting in deeth) 20min Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 25. Wes case referred to medical eximiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 / ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 2 Accident

the ettending physician end hed for use as the bunel-transit certificate be executed Box 68760. The law requires that the death Division of Vital Records, P.O. by ate has been signed pega 2 should be de certificate has Physician: s effer death.

al Director: After this ce or Attending

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

by

Completed

Be

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Expansion must be notified at

the Merylend

filed within 72 hours after death

Hygiena.

2 should be fi end Mental I

permit. Pages 1 and 2 sh Depertment of Health end Important: If Item 27 Is m any Injury or other traum DDCs.

Physician /Medical

Examiner

Physician/Medical Examiner

þ

Completed

Be

2

Certification:

edical

filled in by

completely

within 24 hours of To the Funeral C

Maryland 21215-0020

1 Tyes 2 No

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and menner stated.

29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

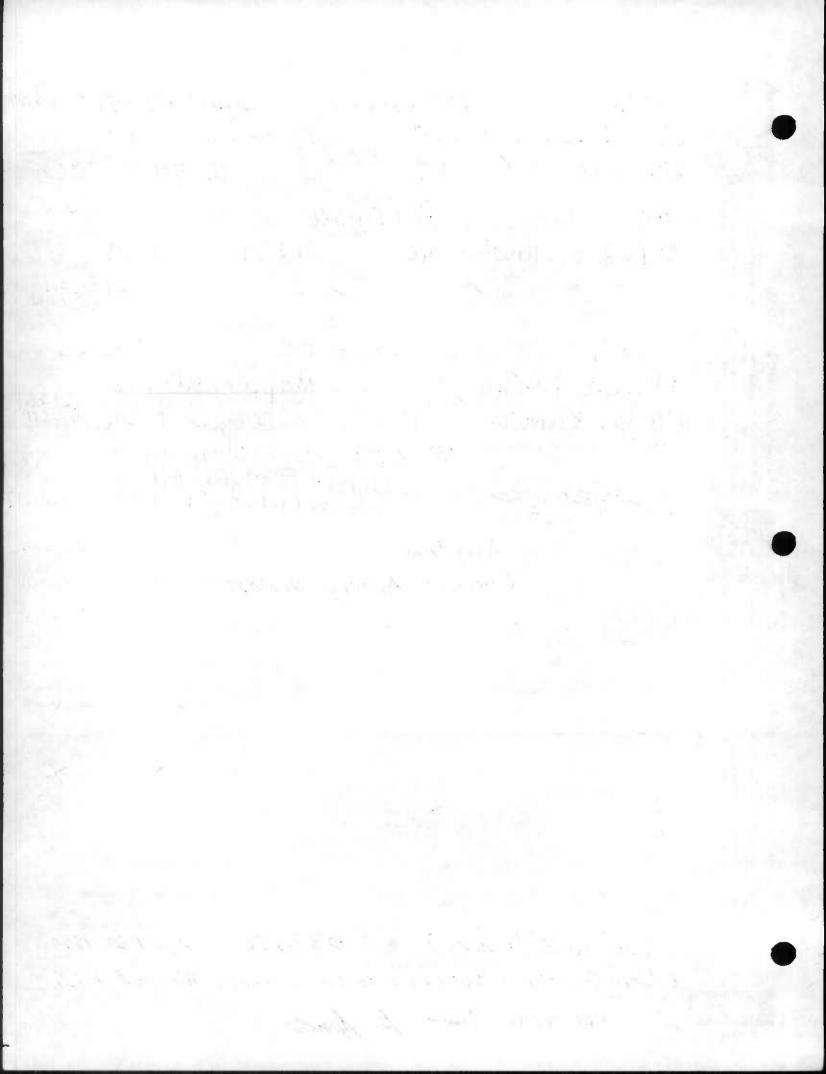
Baltimore, Maryland 5601 Loch Raven 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

Registrar

6 Could not be



28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)



Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0020

The law requires that the deeth certificate be executed or Attending Fafter death. To the Hospital or A within 24 hours after To the Funeral Directomplataly filled in by

Director: A

State Registrar

edical

29a. Certifier

(Check only one)

29b. Signature and title of court

29c. License number 026358

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

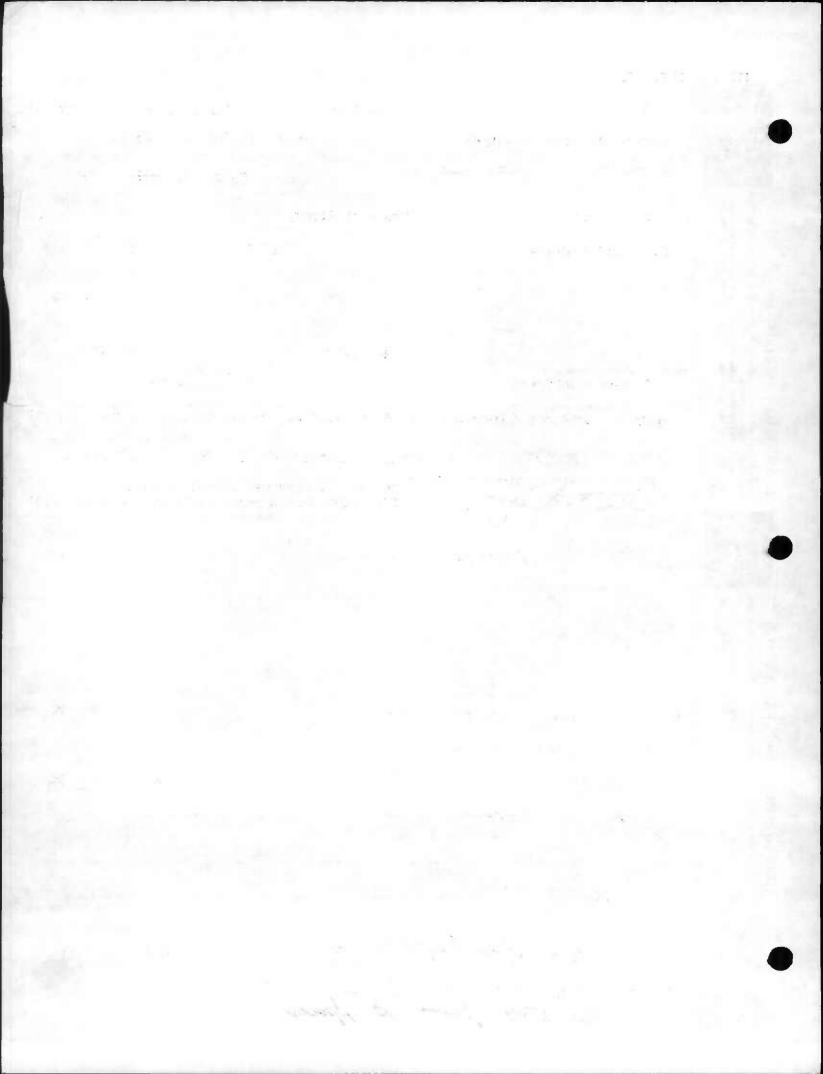
Cortifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) and manner as stated.

29d. Date signed (Month. Dev. Year)

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Weigel .. M.D., Prince Frederick, Maryland 20678 John

32. Registry's Signature 31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Death 4:42 pm **Physician**)ebster Apri JOHN /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore VA saltimore Baltimore Medica enter s. Dete of Birth (Month, Day, Year)

April 26,1927

9. Birthplece (State of Foreign Country)

Maryland If Under 1 Yaar Months Days If Undar 24 Hrs Hours Min. 5. Sociei Security Number 8. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 10M 2□ F Days 217-20-1192 Yrs 72 **Director** Usuel Residence of Decedent filed within 72 hours efter deeth with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore County Baltimore Maryland 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 21220 3526 Honeysuckle Lane USA Funeral 12. Wes Decedent Evar in U,S. Armad Forces? 13. Wes Decedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuben, Maxican, Puarto Rican, atc.) 11. Merital Status 14. Race - American Indien, Black, Whita, atc. 1X Yas 2 No If Yes, Give Yaar or Datas: 1 Never Merried 2 Married 1□ Yes 2 No Specify: White þ 3 Widowed 4 Divorced WW 11 Completed Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Heelth end Mental Hygiena. Important: If Itam 27 is marked other than "na any injury or other traumatic event, the Media. 900.6. Elamantary/Secondary (0-12) College (1-4or 5+) Route Salesman Stroehman's Bakery 10 yrs. N/A 17. Fathar'a Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Melden Sumema) Be Morgan Webster Mary Marguerite Willing 2 19a. Intermant's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Mrs. Wilma E. Webster 3526 Honeysuckle Lane Baltimore, Md. 21220 20b. Plece of Disposition (Neme of cametery, crematory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1X Buriai 2 ☐ Cremation 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Other (Specify) 5-3-99 Parkwood Cemetery Baltimore, Maryland 21. Signature of Funeral Service Lic 22. Nama and Address of Fecility Lassahn Funeral Home complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, only one causa on each line. Party Enter the diseasa, or comshock, or heert feilure. List only Approximata Intervel Between Onset and Deeth **Physician** Immediata Ceuse (Finel diseese or condition resulting in deeth) /Medical Oue to (or es a consequence of): Examiner Physician/Medical Examiner neumonia The lew requires that the deeth certificate be axecuted attending physician end for use es the burial-transit Sequentielly list conditions, if eny, leeding to immadiete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequence of) Abdominal Division of Vital Records, P.O. Box 68760, Lnfection Due to (or es a consequence of): Vasc Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the should be detached 23b. Did tobacco use contribute to the cause of death? 1 1 10 2 □ No 3 □ Probably 4 □ Unknown oronary by 24e. Wes en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? Completed hronic Obstruct hes Polymoran C 25. Wes case reterred to medical exeminar? 1 ☐ Yes 2 ☐ No certificate disease 1 ☐ Yas 2 ☐ No or Attanding Physician: Be director 28. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 ₽ No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this Aftar thi 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury Certification: 28c. Injury et Work? 28d. Dascribe how injury occurred 5 Pending investigation 1 (Natural deeth. 1 ☐ Yes 2 ☐ No after deeth

Director: A 2 Accident 6 Could not be determined 3 Suicida 28e. Pleca of Injury - At homa, tarm, street, tectory, offica building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide hin 24 hours aft the Funeral DI npietely filled in edical 1 Certifying Physician: To the best of my knowledge, deeth occurred et tha time, date end pleca, end due to the ceuse(s) end menner es steted. 29a. Cartifier 2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. To the I within 2 To the I complet 29b. Signeture and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00 30. Name end eddrass of person who completed cause of death (Item, 23a) (Type, Print) 10 0 31. Dete filed (Month) Dey, Year) 32. Registrar's Signeture State Registrar

DHMH 16 Ray 6/95

ALL YOU SEE SEE STATE OF THE ST

age did to

3. Time of Death

29d. Date signad (Month, Dey, Year)

SALISBURY, MD

21804

2. Dete of Deeth Month

Physici /Medic		PAULINE	D. W	ORTHING	ON					April	28	1999	2015	
Examir		4e. Fecility Name (/	f not institution, g	ive street end no	ımber)			4	b. City, Town,	or Location of De	eth 4c. Cor	inty of Deeth		
		PENINSU	LA REGIO	NAL MED	ICAL CE	NTER			SALISH	BURY	WIC	OMICO		
Funeral Director		5. Sociel Security N 221-50-72		Sex 1☐M 2∏F	7. Age (In yrs	. last birthday) Yrs.	If Under	Year Deys	Hours N	lin. 8. Date of (Month, DEC 2	Birth Dey, Year) 27, 1918	9. Birth Cou DEL	place (Stete or For htty) AWARE	əign
ъ		Usual Residence of	Decedent				1							
how		10e. Steta	10b. County		10c. C	ity, Town or Lo	ocation						10d. Insida City Lin	nits
to the Marylan r 28a-f show	cto	DELAWARE	SUSSE	X		MILLSE	BORO						1 X Yes 2 □	No
th with th	i Director	10e. Street end Nur	nber IDYWINE	Δ D Δ D T M F N	JTC		10f. Zip (199	066			itizen of What Country?		
Pa 23	era	11. Maritel Status	(DIWING)		edent Evar in U	I.S. 13	Wes Decede			(Specify Yes or		U . S . A .		
020 urs after dea al', or items	by Funerai		ed 2 Married	Armed F	orces? 2 No ive		If Yes, speci 1 ☐ Yes 2		of Hispenic Origin? (Specify Yes or No- Cuben, Mexican, Puerto Rican, etc.) No Specify:			Bleck, White, etc. Specify: WHITE		
15-002	ted	/Snec	15. Decedent's l			16e. Dece	dent's Usual	Occupi	etion	working	16b. Kind o	f Businass/In	dustry	
21215-0020 of within 72 hours afficiene. In than "natural", or or than "natural", or the Wades Every	should be filed withir and Mental Hygiene. s marked other than turnatic event, Te M	Elamantary/Seco	1		(1-4or 5+)		DO NOT use	retired	furing most of	WOIKING	SENIC	SENIOR CENTER		
Hygothe ent.		17. Fether's Neme						18. Mother's l	Name (First, Midd	lle, Maiden Sur		_		
Maryland d 2 should be file the end Mental Hy ith end Mental Hy raumatic event		PAUL I	ECKER		18. Mother's Name (First, Middle, ELVA ORRELL									
		19e. Informent's Ne	me/Ralationship	(Type, Print)		19b. Maili	ng Address	(Street	and Number or	Rure/ Routa Nur	nber, City or To	wn, Stete, Zij	Coda)	
		PATSY W.	ROWE /	DAUGHTE	3	P.O.	BOX 4	1, (CEAN V	IEW, DEI	AWARE]	9970		
Baltimore, semit. Peges 1 en Sepertment of Heal mportant: If Item 2 iny injury or other ince.			osition Cremation 3		Stete	Place of Dispo cemetery, cred	metory or oth	ner plac		Dete ES 4/29		on - City or To		
Baltimol permit. Peges Depertment of Important: If it any injury or o		21. Signeture of Fu	neral Service Lice	insee . Wa	tem	WA		FUNE	ERAL HO	ME, INC.			_	
		23a. Part1. Enter the	ne disease, or cont t feilure. List ont	mplications that	caused the dee	th. Do not ent	er the mode	of dyln	g, such es care	diec or respiretory	errest,	, DL	Approximete Intervel Between	Т
Physician /Medical Examiner		Immediate Cause (disease or condition resulting in death)	Final		TE AND (L FA	ILURE				Onset and Death YEARS	
	ē				Due to (or es e consec	quence of):					į		
death certificate be executed eathending physician and of for use as the buriel-trensit	i Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury										1		
rtificete be ex ng physician as the buriel	sician/Medicai	thet initiated events resulting in deeth) L		c	Due to (d	or as e conseq	uence of):					1		
Box (sath certif attending for use a:	an			l d										
		Pert II. Other elgnifi	cent conditions	contributing to d	eath but not res	sulting in the u	nderlying ca	use give	en In Pert I.	23b. D	d tobacco uea	contributa t	o the cause of dea	ith?
S, P.C		ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE								11	1 Yes 2 No 3 Probat		bably 4 Unkn	owi
() - 00	be of by	ACUTE GOUTY ARTHRITIS							24a. Wes	es en eutopsy rformed?	CC	ara eutopsy finding eileble prior to empletion of cause deeth?	js	
II Re(mo									1[⊋Yes 2XN	0 1	□Yes 2XNo	
Vital I	Be C	25. Was case rafarr	ed to medical						26. Place of I	Death (Check oni				
of Vita Physician: this certific	0	examinar?	No	Hospital: 1X	Inpatiant 2	ER/Outpetier	nt 3 DO/	Othe	AP1	g Homa 5□Re		Other (Spaci	fv)	
on of oding Phys th. After this of funeral dil	ition: T	27. Manner of Deeth 1 ANetural 2 Accident		28e. Date (Mor	of Injury oth, Dey Year)	28b. Time of finjury		c. Injury Work	et ?		e how injury oc			
Division of Attending F after deeth. I Director: After d in by the funer	ertification:	3 ☐ Suicide 4 ☐ Homicida	6 Could not datarmine	ha	M 1 □ Yas 2 □ No					al Route Number,				

State Registrar 31. Dete filed (Month, Dey, Yeer)

29b. Signature end title of certifier

29e. Cartifiar

1. Decedenf's Neme (First, Middle, Lest)

MICHAEL ATKINS, M.D. 32. Registrar's Signature

30. Name end eddress of person who complated cause of deeth (Item 23a) (Type, Print)

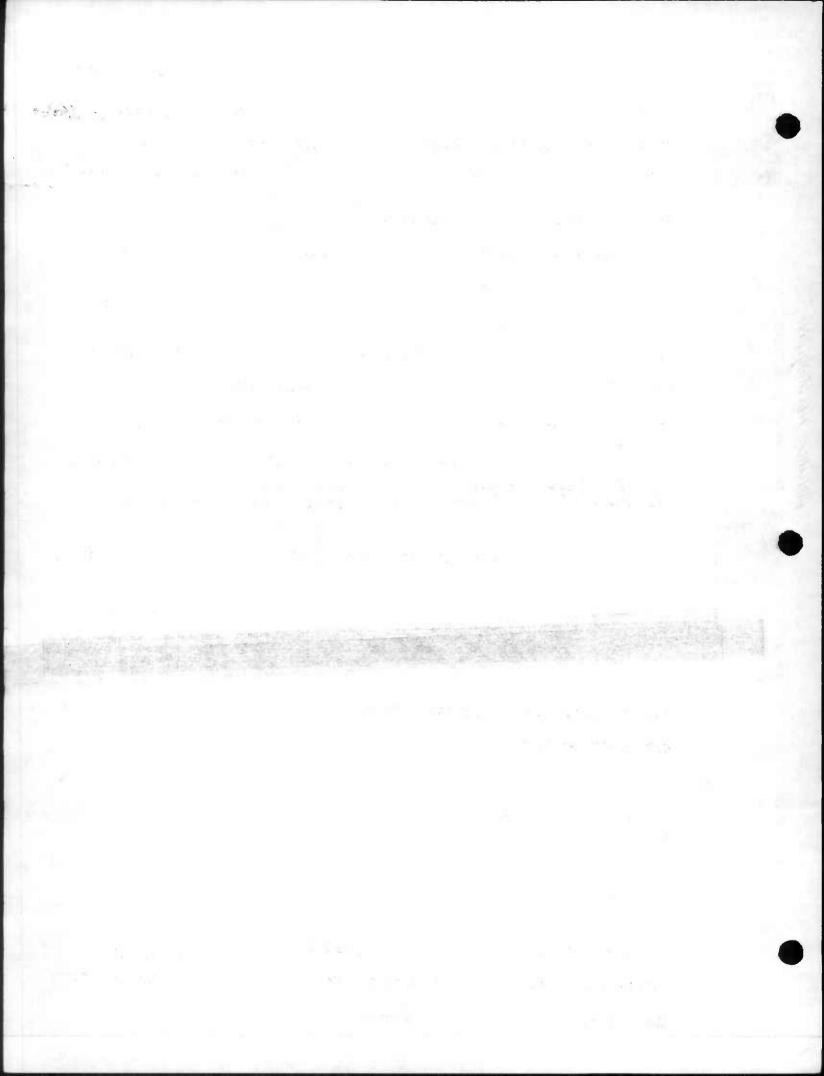
1104 HEALTHWAY DRIVE

Tertifying Physician: To tha best of my knowledga, daath occurred et the tima, data and placa, and due to tha causa(s) and mannar as statad.

2 Medical Examíner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred at tha tima, data and place, end due to tha causa(s) end manner stated.

29c. License number

139813

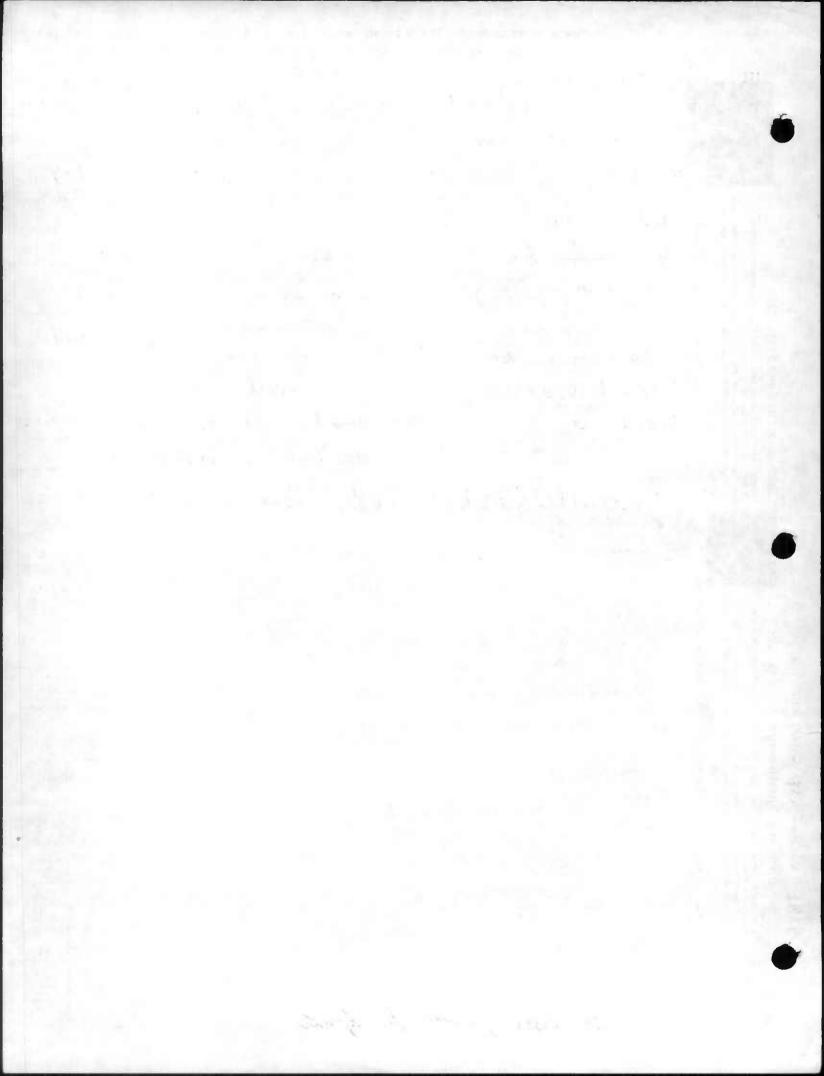


mended	d Item #19a,19b per FH G772 6/10/99 EW Certificate of Death Reg. No.				
ysician Medical	1. Decadent's Name (First, Middle, Last) A Facility Neme (If not institution, give street and number)	Webb	2. Date of Dea Month or Location of Death	24, 1	3. Time of Death
eral	5. Social Security Number 6. Sex 7. Age (In y 212-26-3893 10 M 20x 96	Sing + Rehat Bunder 14 Under 241	1+0	1500000	9. Birthplace (State or Foreig Country) VA
or items 23a or 28a-f show infrat must be notified at 7 Funeral Director	Usuel Residence of Decedent 10e. Stete 10b. County 10c.	City, Town or Location			10d. Inside City Limits
	MD N/A	BALTO			1 TYPes 2 □ No
	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?	
	1912 W. NORTH AVE	21217		U.S.A.	
by Funeral	11. Maritel Stetus 1 Never Married 2 Married 1 Never Married 2 Married 3 Nodewed 4 Divorced 12. Was Decedent Ever if Armed Forces? 1 Yes, 2 No If Yes, Give	n U,S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)		- American Indien, White, etc. Black
Completed by F	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation	working	16b. Kind of Busi	iness/Industry
	Elementery/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of life. DO NOT use retired)	WOINING		
	6th 17. Father's Neme (First, Middle, Last)	Housewife	Name (First, Middle,		mestic
item 27 ie merked other other treumetic event, I To Be Co	Sidney Stanton	Ce	rnata Fi	emina	
	19e. Informent's Neme/Relationship (Type, Print) Cernata Fleming Morse/Niece	19b Mailing Address (Street and Number of 2412 Beacon Hill Rd, Ale	exandria yA	22306-1606	ma 21213
	20e. Method of Disposition 20th	b. Plece of Disposition (Name of cemetery, cremetory or other plece)	Date	20c. Location - C	ity or Town, Stete
To the Functal Director: After this certificate has been signed by the ettending physician and Signed by the ettending physician and Signed by the funeral director, page 2 should be detached for use as the burlal-transit	4 Donetion 5 Other (Specify) 21. Signeture of Fuyeral Service Licansee	Baltimore Cem 22. Name end Address of Fecility	4-29-99		
	Malua State	Betts Funeral Home 1129 N. Caroline St Balto, MD 21213			Home 21213
	23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of):				
	b. Arma				
	Sequentially list conditions, Due to (or es e consequence of): if any, leading to immediate cause. Enter Undertying				
	Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.				
	Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause given in Pert I.				ribute to the cause of death
	Congrative Heart Failure		101	1 Yes 2 No 3 Probably 4 Unknow	
	Chronic Obstructive Lune	Disease	24a. Wes a perfor	an eutopsy med?	24b. Were eutopsy findings aveilable prior to completion of cause of death?
			1□ Y	es 200No	1 Yes 2 No
	25. Was case referred to medical examiner? 1 Yes 2 No Hospitel: 1 Inpatient 2	0	Deeth (Check only or		
	27. Manner of Deeth 28e. Dete of fnjury	EH/Outpatient 3LI DOA 4 ANursin	4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred		
	Neturel 5 Pending (Month, Day Year,	fnjury Work? M 1 Yes 2 No	2 □ No		
	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Spe	at home, ferm, street, factory, office scity)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
edicai (29e. Certifier (Check only one) 12 Certifying Physician: To the best of my k 2 Medicaf Examiner: On the besis of exam end menner stated.	knowledge, deeth occurred et the time, date end pla inetion end/or investigation, in my opinion, deeth o	ace, end due to the occurred et the time, o	cause(s) end men date end place, ar	ner as steted. Id due to the cause(s)
M	29b. Signature and title of certifier 29c. License number D3 4 L F 0 - MD 29d. Date signed (Month, Day, Year) 4 2 8 - 99				(Month, Day, Year) 28-99
	A				
	30. Name and address of person who completed cause of deeth (II) Michael A Randhh MD 333	tom 23a) (Type, Print) 3 N. Calvert St #USS	2 11	. m 1	7.2.4

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 10E Certificate of Death ITEMS: #19A-B PFR F.H. G771 5-3-99 WR 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Woodly, Jr Edward Month ASO AM **Physician** APRIL 28 1999 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner AGNES HOSP BALD MORE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. (Month, Day, Yeer) 6. Sex, 1 M 2 F 7. Age (In yrs. lest birthday) 5. Social Security Number 9. Birthplece (Stete or Foreign Country) Yrs. 106-40-6392 Director Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or itsems 23s or 28s-f sho treumstic event, the Medical Examiner must be notified at 1 Yes 2 □ No Baltimore Md Director NA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? **GWYNN** ·A 21229 sure , 5 Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Raca - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status I ☐ Yes 2 No If Yes, Give / Yeer or Detes: 1 Never Merried 2 Merried Black altimore, Maryland 21215-0020 1□ Yes 2 No Specify: P 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pemit. Peges 1 and 2 should be filed within 7 Department of Haalth and Mantal Hygiene. Important: if Item 27 is marked other than "n any injury or other treumatic event, ma Med price. Werner Ent Elementery/Secondery (0-12) College (1-4or 5+) 12th grade Trailer NA 18, Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Edward Geraldine Woodly 0 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Woodly 400 GWYNN AVE. Balto, Md ZIZZG leans WOODLY 20b. Piece of Disposition (Neme of cemetery, cremetery, or other place) Dete 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stele 5-3-99 butus Mem 4 □ Donetion 5 □ Other (Specify) Name end Address of Fecility 21. Signature of Funerel Service Licensee Lerenne walnust 300 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line. Approximete Intervel Between Onset end Death **Physician** Immediete Ceuse (Finel disease or condition resulting in death) /Medical LIVER CIRRHOSIS year Examiner Due to (or es e consequence of): Examiner wriff, RENAL FAI WRE physician and the burial-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury thal inilialed events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of): 68 WOODLY, EDWARD, D. esn 23b. Did tobacco usa contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed pega 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medicei 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2⊠ No 20 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) funeral 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Maturel aftar death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours 18 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) HORFA RUS MD 12703 APRIL 128, 1999 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) ST. AGWES HOSP 900 CATON AVE BAUN' MORE HOREA RUS 31. Dele filed (Month, Day, Year) 32. Registrer's Signature Registrar 3 1999 **DHMH 16 Rev 6/95**

gots



Piease Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death (00 **Physician** Month Daphne oung Apri 1999 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Memorial Hospital Baltimore 100 If Under 1 Year | If Under 24 Hrs. Months | Deys | Hours | Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) B. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Trinidad Funeral Months Deys 10 M 2 F 26-46--19-19271 Director 621 100+ ndies Usuel Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show treumatic event, tre Medical Examiner must be notified at 1 Yes 2 No Md Baltimore Director NA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5912 21239 . S.A Torkwood Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiana. Important: If Item 27 le marked other than "natural", or hanny no other treument. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black by 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry UNI 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Health A10 NA 17. Fether's Neme (First, Middle, Last) 1B. Mother's Name (First, Middle, Maiden Sumame) Be Road Alexander Demas 2 19e_Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, Stete, Zip Code) Uswald Baltimore Son 5938 young Hlameda 21239 The 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 4-30-99 Randallshwa and Memorial SIDA 21. Signeture of Funeral Service Licensee 22 Name and Address of Fecility la Balto, md Wome 30 0 Avenue 21215 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical mue Examiner Examiner RONS Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of): Schrift Physician/Medical Due to (or es e consequence of) Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23h. Dtd tobacco use contribute to the cause of death? posted hellite 1 Yes ON No 3 Probably 4 Unknown þ Completed 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? peen 10 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: PEmpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No within 24 hours after death. To the Funerei Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, tactory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner steted. Medical 29e. Certifier complately (Check only one) \$ 29d. Date signed (Month, Day, Year) 29c. License number A . O 15 p2. 26

Registrar

State

30. Name and Wress of person whe

MAY

31. Dete filed (Month, Day, Year)

Baltimore, Maryland 21215-0020

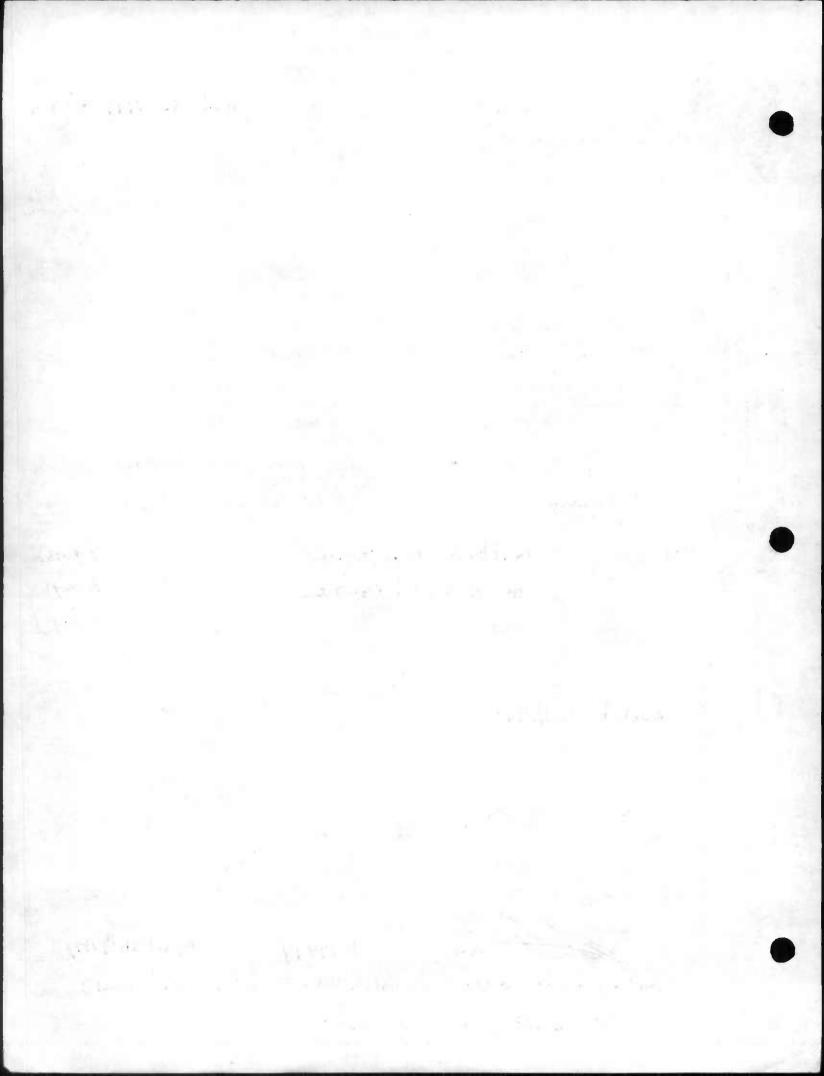
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Division of Vital Records, P.

completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signeture

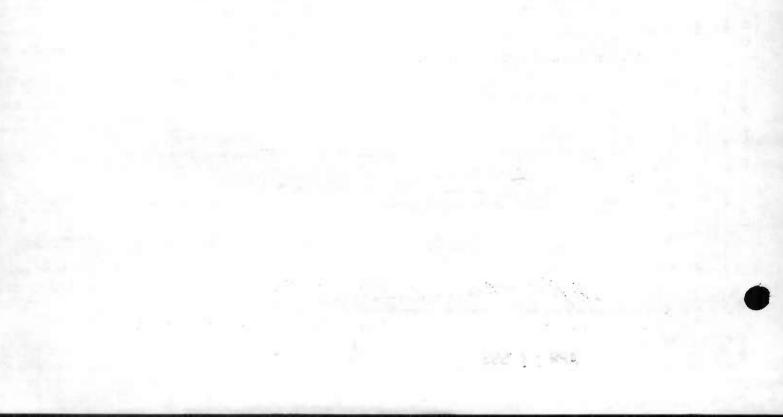
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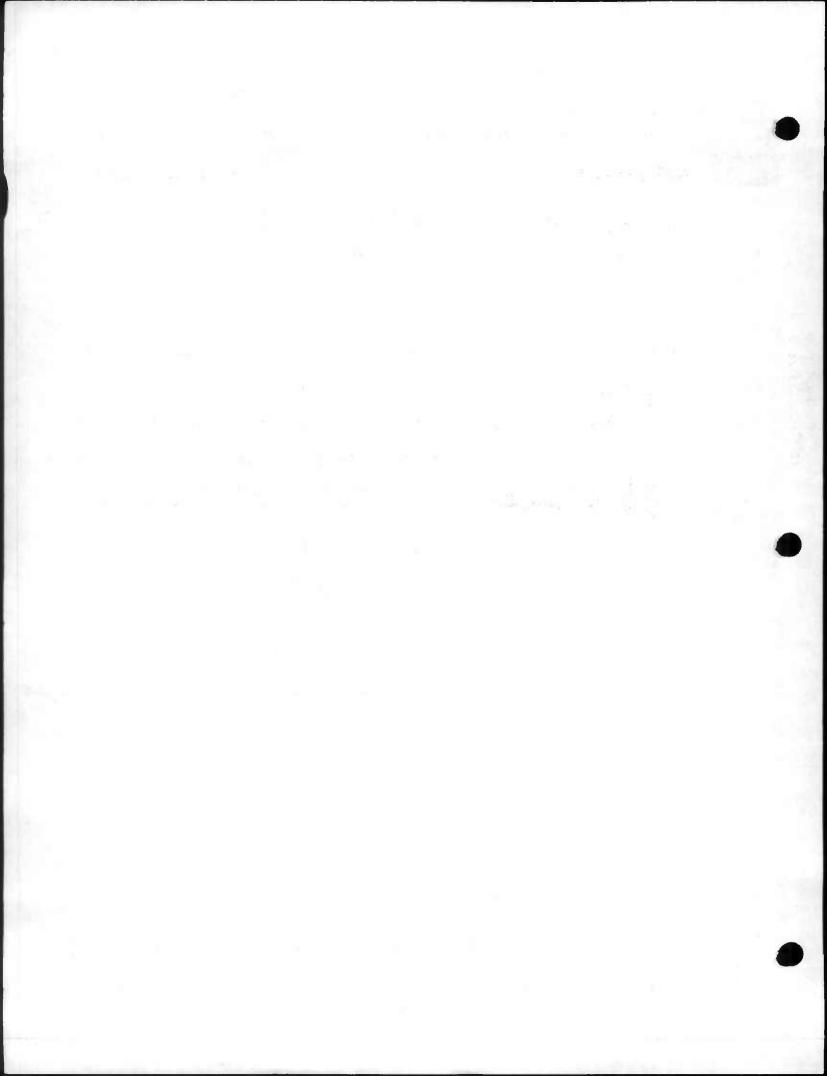
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		State of Marylan	nd / Department of Certificate or	Health and Mental Hy	giene 9 14292					
Physi /Med Exam	lical	1. Decedent's Neme (First, Middle, Last) Ruth Archie 4e. Fecility Neme (If not Institution, give street end number) PENINSULA REGIONAL MEDICAL CEN	TER	2. Dete of Detendenth Alacete 4b. City, Town, or Location of Deeth SALISBURY	Day Yaer 2350					
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs.		if Under 24 Hrs. 8. Date of Birt						
Be-f show	Director	10e. State10b. County10c. CitMarylandSomersetMa	ty, Town or Location		10d. Inside City Limits 1 ☐ Yes ②【XNo					
h with th		10e. Street and Number 5276 Whites Rd.	10f. Zip Code 2183	1	10g. Citizen of Whet Country? USA					
-0020 hours effer deeth with the Maryland urel', or terns 23s or 28s-f show at Exarrigner must be notified at	by Funeral		,S. 13. Was Decedent of if Yes, specify Cu	Hispanic Origin? (Specify Yes or No ban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc. Specify: Black					
3 215-0020 thin 72 hours off e. an "neturel", or	Completed	15. Decedent's Educetion (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+)		upation e during most of working red)	16b. Kind of Business/Industry					
and 21 dbe filed wi	Be	17. Father's Name (First, Middle, Last)	Domestic	18. Mother's Neme (First, Middle,	Self Employed Meidan Surneme)					
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Marylen Important: If frem 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Med cal Examiner must be notified at	To	19e. informent's Neme/Reletionship (Typa, Print) Delores Schoolfield, Mother 20e. Method of Disposition 1™ Burial 2 □ Cremetion 3 □ Removal from State	5276 Whites Place of Disposition (Name of cametery, cremetory or other p	et end Number or Rurel Route Number Rd. Marion Stat Dete	zion, Md. 21838 20c. Location - City or Town, State					
Baltimore, permit. Pages 1 at Department of Hea Important: If item: any injury or othe	NIE S	21. Signature of Funda & Service Licensee	etery 4/17/99 ress of Facility Smith Funeral Hom x 1687, Easton, N	ne Maryland 21601						
Physician /Medica Examine	i r	resulting in deeth) Dua to (c	FUMONIA- or es a consequance of):		rrest, Approximate intervel Between Onset end Death					
68760, tificate be executed gphysician end es the buriel-trensit	Medical Examiner	Cause (Diseesa or injury c.	or es e consequence of):	√						
P.O. Box 687 et the death certificate by the ettending physeleached for use es the	Physician/Medi	d. Part ii. Other eignificent conditions contributing to death but not res	sulting in the underlying cause		tobacco use contribute to the cause of death					
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Vital Rec					Yas 2 1 No 1 Yas 2 No					
	tion: To Be	25. Wes case refarred to medicel examiner? 1 Yes 2 No	28b. Time of Injury 28c. in	26. Pleca of Deeth (Check only of Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residual} \) Residual Perconditions? 28d. Describe of Ork? Yes 2 \(\text{No} \) No						
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he Hospit in 24 hour he Funers	edical	29a. Certifiar (Check only one) 1 Certifying Physician: To tha best of my kno 2 Medical Examiner: On tha basis of axamina and manner stated.	owiedga, daath occurred at tha ation and/or investigetion, in my	tima, data and piace, and dua to tha y opinion, deeth occurred et the tima,	causa(s) and mannar as stated. data and place, end dua to the ceuse(s)					
To the within	N	29b. Signature end title of certifier	1 M.D 29c. Lice	nse number	29d. Date signed (Month, Day, Yeer) Apri / 12, 1999					
1		30. Nama and address of person who completed causa of death (Iter CWANLES FOL ASHAGE M.), J.Y.	m 23e) (Type, Print)		(, vn). > 1 801					
S Regis	tate trar	31. Dete filed (Month, Day, Year) 32. Registrar's Signe	eture /							



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth April Irmgard A. Ahrndt 19, 1999 4:25 P.M. 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number, 4c. County of Deeth Frederick Frederick Memorial Hospital Frederick 8. Dete of Birth /Month, Dey, If Under 1 Year 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1 M 2 D Months Deys Hours Min 340-36-7308 86 Yrs. Feb.01,1913 Germany Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Jefferson Shepherdstown 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 Willowdale Drive 25443 usa 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Yes 2€ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker unknown Own Home 17. Father's Neme (First, Middle, Last)
August Schmidt 18. Mother's Name (First, Middle, Meiden Sumeme) Margarete Kraft 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Gudrun M. Hinz -Daughter P.O. Box 2089, Shepherdstown, WV 25443 20b. Place of Disposition (Name of cemetery, cremetory or other place)
Omps Crematory 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 4/21/99 Winchester, VA 22. Name end Address of Fecility
Melvin T. Strider Co., Inc. 21. Signature of Funerel Service License 23a. Pert 1. Erker the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in deeth) as aiden Due to (or es a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 12 Unknown 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy

Physician /Medical Examiner

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994 page 2

certificate

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neral Director: After this or
y filled in by the funeral dire

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The lew requires that the death certificete be executed

Box 68760.

P.O.

Records,

Division of Vital or Attending Physician: Physician/Medicai Examiner

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Certification:

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29a. Certifier

(Check only one)

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Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

à

Completed

ten 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Modical Examinal must be not the di-

parmit. Pages 1 and 2 should be filed within 72 hours efter deeth Department of Health and Mentel Hygiene.

Saltimore, Maryland 21215-0020

with the Merylend

Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. leukenic rafeles 26. Piece of Deeth (Check only one) Hospitel:

25. Wes cese referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work?

27. Menner of Deeth 1 D Naturel 5 Pending investigation

2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Dey Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

completion of cause of deeth?

1 Yes 20 No 1 □ Yes 2 □ No

28d Describe how Injury occurred 1 ☐ Yes 2 ☐ No

W. 9th ST) Frederick MICINOI

281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

111 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated.

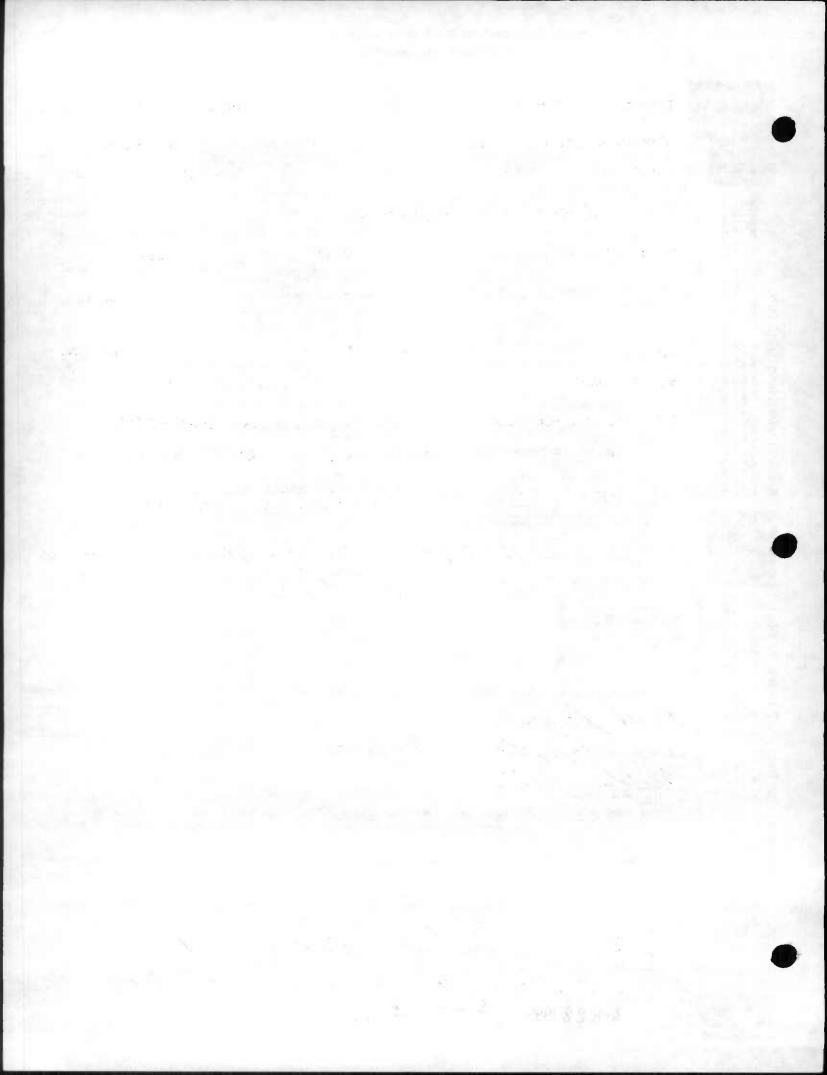
29b. Signeture end title of certifier 226

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

31. Dete filed (Month, Dey, Year) APR 22 1999 32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** Apri 1999 0520 ABELL RUTH NAOMI /Medical 4c. County of Deeth 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street end number) Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** Deys Months 1 □ M 2 X F Hours Yrs. 213-16-1000 86 Director APRIL 1, 1913 MARYLAND Usual Residence of Decedent with the Meryland 10c. City. Town or Location 10d. Inside City Limits 10e. Stete 10b. County 28a-f ahow r than "natural", or items 23a or 28a-f ahor the Wedicel Examiner must be notified at 1 X Yes 2 □ No Director MARYLAND WASHINGTON **BOONSBORO** 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Peges 1 and 2 should be filed within 72 hours after death a Deportment of Haalth and Mental Hygiena. Important: If Item 27 is marked other than "natural", or items 23a eny Injury or other traumatic evant, its Medical and Once. U.S.A. 21713 141 SOUTH MAIN STREET Funeral 14. Race - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Yeer or Detes: 1 □ Never Merried 2 □ Married 1 ☐ Yes 2 ☑ No Specify: þ 3 N Widowed 4 □ Divorced WHITE Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) AIRCRAFT MANUFACTURE BLUEPRINT MAKER 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) NOBLE VICTOR SPICKLER BERTHA MATILDA BOWERS 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) PAULINE L. RENNER/SISTER 618 NORTH MAIN STREET, BOONSBORO, MARYLAND 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) BROADFORDING CEMETERY 4/19/99 HAGERSTOWN, MARYLAND 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility 7606 Old National Pike anem PAUL M. DEAN BAST FUNERAL HOME Boonsboro, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final diseese or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of): Physician/Medical Examiner otheroselere ettending physician and for use as the bunal-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events septimized to the control of the control Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Due to (or as e consequence of): resulting in death) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? the been signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown congestive heart failure þ 9 has been sig 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy Completed page 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Director: After this cartificate d in by the funaral director, pag or Attending Physician: Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No L_o 12 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of injury 27. Manner of Deeth Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1. Neturel 1 Yes 2 No death 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by efter 4 \ Homicide within 24 hours of To the Funeral Completaly filled 12 Certifying Phyelcien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and plece, end due to the ceuse(s) and manner stated. edicai 29a. Certifier (Check only one) 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 032518 Keedyssille Maryland 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tr Guedenet 100 Geeting

Lane

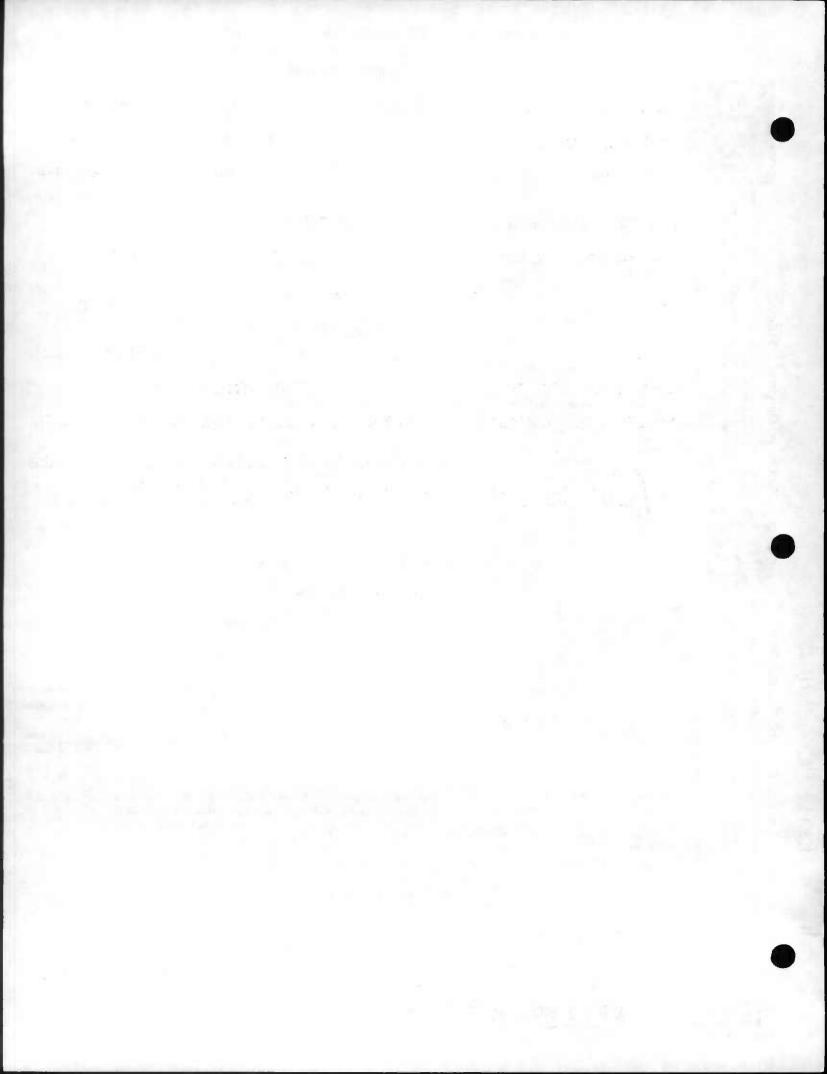
32. Flegistrar's Signature

State Registrar

31. Date filed (Month, Day, Yeer) APR 1 9 1999

DHMH 16 Rev 6/95

Coth Maoni Abel



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 16 99 1052 4 BARIA CLARYECE /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Deeth **Examiner** ATLANTIC GENERAL HOSPITAL

5. Social Security Number 6. Sax 7. Age (In yrs BERLIN If Undar 24 Hrs. Hours Min. WORCESTER Birthplece (State or Foraign Country) If Under 1 Year 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Yeer) **Funeral** 1□M 2XF Months Deys Yrs. 428-07-7633 86 Director 1-13-13 MISS Usuel Residence of Decedent 10e. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or itsms 23s or 28s-f shot traumstic event, the Modical Examinar must be notified at MD. BERLIN WORCESTER 1 Yes 2 No Director 10a. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 77 LOOKOUT POINT 21811 USA Funeral 14. Race - American Indian, Bleck, Whita, atc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forcas? 1 Yes 25 No If Yes, Give Year or Detes: Pages 1 and 2 should be filed within 72 hours after 1 Nevar Married 2 Married Department of Health and Mantal Hygiena. Important: If Item 27 Is marked other than "natural", or any Injury or other traumatic event, the Modical Exami 1 ☐ Yes ZNo Specify: Specify: WHITE by 3 Widowad 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) SALES SECRETERY 18. Mother's Nama (First, Middle, Maidan Sumema) 17. Fathar's Nama (First, Middla, Last) Α. CONRAD NESOSSIS ANNIE LAMEY 2 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 20b. Plece of Disposition (Nema of cametery, cremetory or other place)

POINT BERLIN MD. 21811

20c. Location - City or To CAROLYN B. JOHNSON Baltimore, 20c. Location - City or Town, Stata 20e. Method of Disposition 1 ☐ Buriel 20 € Cremetion 3 ☐ Removel from Stete SALISBURY CREMATORY 4-17 SALISBURY, 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funery Service License 22. Nama and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD. 21811 23a. Pert1-Enter the disease, or complications that causad the death. Do not enter the moda of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one cause on each line. Approximeta Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es e consequança of): resulting in deeth) Lest 23b. Did tobacco use contribute to the cause of deeth? Pert II. Other significent conditions contributing to death but not resulting in the undarlying ceuse givan in Part I. BONDER RESECTION signed by 1 Yes 25 No 3 □ Probably 4 □ Unknown þ TRUCTIVE COUN CANCEN 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy performed? Completed completion of ceuse of deeth? has 2 12 No 1 Yas 1 Yes 2 No this certificate To the Hospital or Attending Physician: Be 25. Wes cese referred to medical 28. Place of Daath (Check only one) examiner? Hospital: 1 Appatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2□No 2 3 DOA 27. Menner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Neturel 1 Yes 2 No death. eral Director: A filled in by the f 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) after 4 Homicide within 24 hours a
To the Funeral C 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and menner stated. edicai 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) P 29b. Signeture end title of npleted cause of death (Item 23e) (Type, Print) Werside 31. Data filed (Month, Day, Year) 32. Registrer's Signeture State Registrar

DHMH 16 Rev 6/95

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99-2267-047 Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene 99 MARY KATE Certificate of Death BRITTINGHAM 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Year **Physician** 18, 1999 13:50 PM Mary Kate Brittingham APRIL /Medical 4a Facility Nama (If not institution, giva street and number) 4b City Town, or Location of Death 4c. County of Death Examiner WORCESTER Pocomoke 2153 ORCHARD DRIVE If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 12/31/1997 Birthplace (State or Foraign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 10 M 20 F 1 Yrs. Director 216-51-0532 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 TYYas 2 □ No Director Worcester Pocomoke City 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? death with 2153 Orchard Drive 21851 **USA** Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 72 hours after 1 ☐ Yas 2 ☒ No If Yas, Giva 1 Nevar Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced white Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hyglena. int: If Item 27 is marked other than " Irry or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) 0 Child none 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Be Wayne Thomas Brittingham, Jr. JoElla Becker 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) (father) Wayne Thomas Brittingham, 2153 Orchard Dr., Pocomoke City, MD 21851 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Malhod of Disposition Data 20c. Location - City or Town, Stata № Burial 2 Cramation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Othar (Specify) First Baptist Cemetery 4/21/99 Pocomoke City, MD 21. Signature of Fyharal Service Licensee 22. Nama and Addrass of Facility mo1129 Holloway-Melson Funeral Home, P.A. Michael Dean 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1. Approximata Interval Batween Onset end Death Physician /Medical Immediata Causa (Final diseasa or condition resulting in death) Examine Examiner certificate be asscuted physician and s the bunal-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): 68760 Physician/Medical Dua to (or as a consequence of) 88 Box (P.O. 23b. Did tobacco use contribute to the cause of death? Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 No 3 | Probably 4 | Unknown Records, by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed has 1 Yas 2 □ No 1 XYas 2 No certificate of Vitai 25. Wes case refarred to medical examiner? Be 26. Place of Deeth (Check only ona) examiner/ 1/☑ Yes 2 ☐ No Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 70 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Describe how injury occurred Pedestran Struck 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. tnjury at Work? Certification: After t Division or Attending 1 Natural 5 Pending invastigation 4/18/99 1350 M 10 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 1 Yes 2 No death. 28I. Location (Street and Number or Rural Routa Number, City or Town, Stata) 2 Accident Director: / 6 ☐ Could not be 3 ☐ Suicida after 4 ☐ Homicide Street Md ocomoke edical Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and menner stated. 29a. Certifier

To the Hospital o within 24 hours af To the Funeral Di completely filled in

State Registrar 29b. Signature and titla of certifier

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31. Data filed (Mg

DHMH 16 Rev 6/95

estaner APR 2 0 32. Registrar's Signatura

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

oaks

29c. License number

111 Penn Street, Baltimore, Maryland 21201

OCME

29d. Data signed (Month, Day, Year)

APRIL 19, 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle Last) 2. Data of Death 3. Tima of Death Month Noble Linwood Bradshaw April 19, 1999 5:00 am 4a. Facility Name (If not institution, giva street end numbar) 4b. City. Town, or Location of Deeth 4c. County of Deeth 5414 Moose Lodge Rd. Cambridge Dorchester If Undar 24 Hrs. Hours Min. Sept. 9, 1911 Maryland 5. Social Security Number If Under 1 Year 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 18 M 2□ F Days Yrs 214-07-7994 87 Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Maryland Dorchester Cambridge 10f. Zip Coda 10e. Street and Number 10g. Citizan of What Country? 5414 Moose Lodge Rd. 21613 U.S.A. 12. Was Dacedent Ever in U,S. Armed Forcas? Was Dacedent of Hispanic Orlgin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Ricen, atc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yas 2 💆 No If Yas, Giva Yaer or Dates: 1 Navar Marriad 2 Marriad 1 Yas 2 XNo Specify: Spacify: 3 Widowad 4 Divorced White

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired)

Carpenter

22. Nama and Address of Fecility

Mildred M. Bradshaw/Spouse 5414 Moose Lodge Rd., Cambridge, MD 21613

20b. Placa of Disposition (Nama of camatary, crametory or othar placa)

23af Puril. Entar tha disease, or complications that caused tha daath. Do not entar tha mode of dying, such as cardiac or respiratory arrest, April Shock, or haard failure. List only one cause on each line.

neumonia

Dua to (or as a consequence of)

16b. Kind of Businass/Industry

18. Mothar's Nama (First, Middle, Maidan Sumama)

Daisy Hurley

EastNewMarketCemetery4-22-99 East New Market, MD

Curran-Bromwell Funeral Home, P.A.

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)

Construction

20c. Location - City or Town, Stata

Approximate Intervel Batween Onsat and Daath

Funeral Director 7 is marked other than "natural", or items 23s or 25s-t show traumatic event, the Medical Examinar must be notified at Baltimore, Maryland 21215-0020 Hygiene. permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: if them 27 is marked other any Injury or other **Physician** /Medical Examiner

Physician

/Medical

Examiner

10a State

15. Decedant's Education (Spacify only highast grada completed)

1X Burial 2 Cramation 3 Removal from Stata

College (1-4or 5+)

Elemantary/Secondery (0-12)

17. Fathar's Name (First, Middla, Last)

Noble F. Bradshaw

4 ☐ Donetion 5 ☐ Othar (Spacify)

19a. Informent's Name/Ralationship (Type, Print)

4

20a. Mathod of Disposition

Immediata Causa (Final disease or condition resulting in daath)

Director

Funeral

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Completed

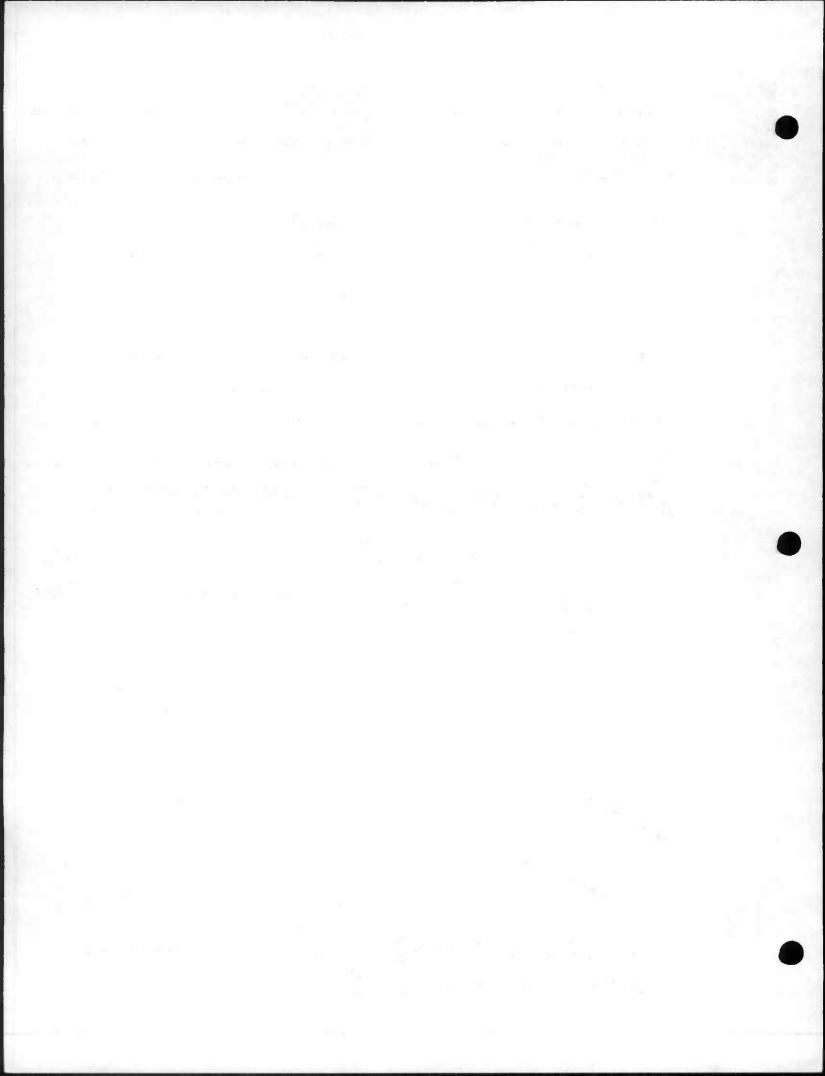
Examiner ettending physician and for use es the bunel-transit the 3 signed b page 2 s certificate

P.O. Box 68760, Records, Division of Vital To the Hospital or Attending Physician: within 24 hours eiter death.

To the Funeral Director: After this certific, completely filled in by the funeral director,

Stage Sequentially list conditions, if any, leading to immadiate ceusa. Entar Undarlying Cause (Disaase or Injury that initiated evants resulting in daeth) Last Physician/Medical Dua to (or as a consaguance of): Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No by 24b. Wara autopsy findings eveilable prior to complation of causa of daath? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was cesa referred to make axeminer? 26. Pleca of Deeth (Check only one) 1 Yes 2 Other: 4 Nursing Homa 5 Masidance 6 Other (Specify) Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Daath 28a. Data of Injury (Month, Day Yaer) 28c. Injury at Work? 28d. Describe how Injury occurred 5 Panding Invastigation 1 DNatural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 28f. Location (Straet and Number or Rurel Routa Number, City or Town, Stata) 3 Suicida 8a. Plece of Injury - At home, farm, straet, factory, office building, atc. (Specify) 4 Homlcide 1 Cartifying Physician: To the best of my knowledge, daeth occurred at the time, dete and place, and due to the ceuse(s) end mennar as stated.

2 Medicel Examiner: On tha basis of exeminetion and/or investigation, in my opinion, death occurred at tha tima, data and place, end due to tha ceusa(s) Medical 29a. Cartifier and manner stated 29d. Date signad (Month, Day, Year) 29b. Signatura and titla of certified ac amprid 31. Data filed (Month, Day, Yeer) 36. Ragistrar's Signatura State Registrar **DHMH 16 Rev 6/95**



tate of Maryland / Department of Health and	Mental Hygiene	298
Certificate of Death	Reg. No.	600
er Bittinger	2. Date of Death Month APRIL 15 1999	3. Time of Death

APRIL

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corke

Physician /Medical **Examiner** 1. Decedent's Name (First, Middle, Last).

Funeral Director with the Merylend

death filed within 72 hours after Hygiene. other permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic assets

altimore, Maryland 21215-0020

Physician /Medical Examiner

attending physician end for use es the buriel-transit ed by the e signed b peen page 2 s certificate hes After this

that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Physician:

Hospital or Attending

Frederick Lester Bittinger 10:15AM 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Cumberland A

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Yeer) Allegany Sacred Heart Hospital Birthplace (Stete or Foreign Country) 7. Age (In yrs. lest birthday) Social Security Number Days 1€ M 2□ F Yrs. 78 March19,1921 Maryland 215-26-9996 Usuat Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23s or 28s-f show the Minical Examiner naut be notified at 1 XYes 2 No Director MD Garrett Grantsville 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 21536 Funeral 184 Main Street 14. Race - American Indien. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritei Stetus Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: 2 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Lift Truck Operator Brick
18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be 10 Grant Bittinger Minnie Durst 19a. Informant's Name/Relationship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Accident, MD 21520 20c. Location - City or Town, State Gloria M. Beitzel/Daughter 574 Beitzel Valley Dr.,
20a. Method of Disposition

20b. Place of Disposition (Neme of cemetery, cremetory or other place)

Date 20a. Method of Disposition 1 ☑ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Grantsville, Grantsville Cemetery April 18, 22. Name and Address of Facility
Newman Funeral Homes, P.A. 21. Signature of Fungral Service Licensee Rumai 04 P.O. Box 275; Grantsville, MD 21536 23a. Part. Enter the Suease, or complications that caused to shock or heart ailure. List only one cause on each line Approximate interval Between Onset and Death or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Immediate Cause (Final disease or condition resulting in deeth) CARDIOPULMONARY ARREST unknown Due to (or as e consequence of): Examiner LEFT LUNG ATALECTASIS unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of): COPD unknown Physician/Medical Due to (or es e consequence of): 23b. Did tobecco use contribute to the cause of death? Pert ti. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 Yes 2 No 2 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Natural 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 | Homicide 24 hours 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end piece, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the F within 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier Purmorary and CRITICAL CARE H0053855 15 1999 MATY 45/12

Registrar

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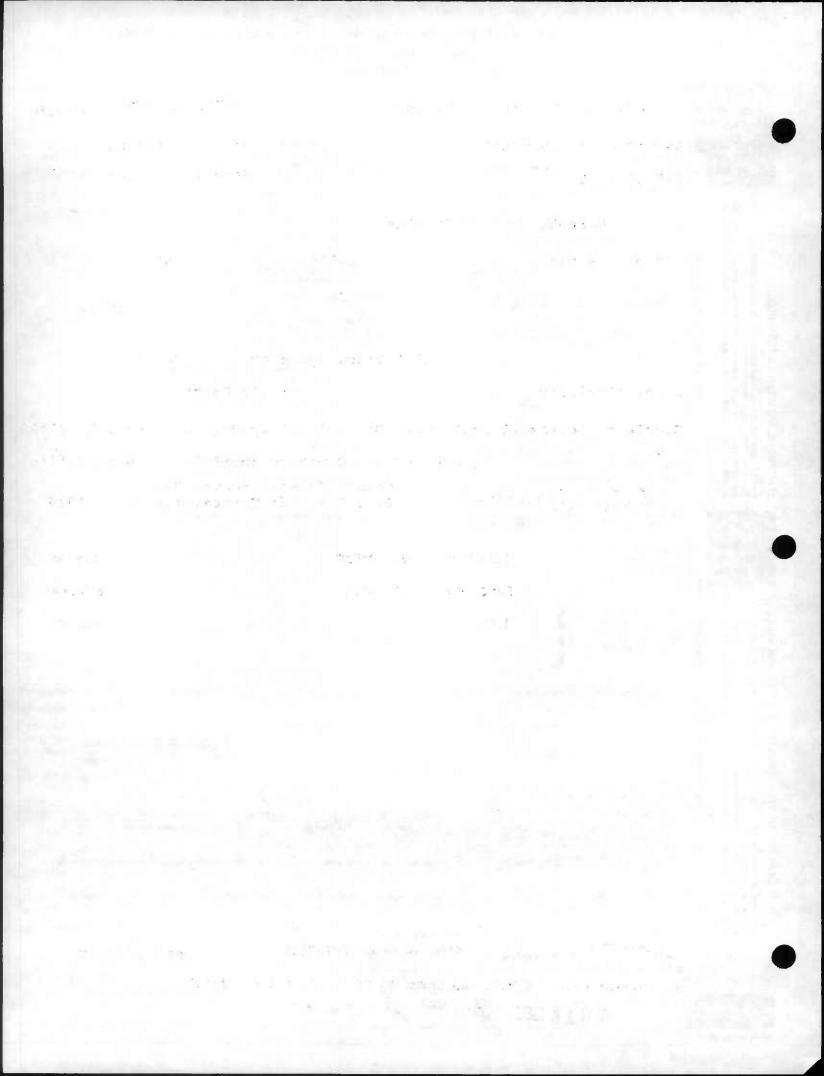
31. Date filed (Month, Dey, Yeer)

APR 16

30. Name and address of person who completed cause of deeth (item 23a) (Type, Print)

STANLEY MATYASIK M.D. 900 SETON DRIVE CUMBERLAND MD

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ARION LUCILLE 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 2 XF Months Days Hours Yrs. 83 220-64-6873 JAN. 26, 1916 PENNSYLVANIA Usual Residence of Decedent 10c. City, Town or Location 10e State 10b. County 10d. Inside City Limits 1 Yes 2 No WASHINGTON HAGERSTOWN 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 22125 RINGGOLD PIKE 21742 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GEORGE W. BURKHART EDITH V. MILLER 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) EUGENE W. BECKER/HUSBAND 22125 RINGGOLD PIKE, HAGERSTOWN, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SMITHSBURG CREMATORY 4/19/99 SMITHSBURG, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME harles 327 W. KING STREET nowa PO BOX 821, MARTINSBURG, WV 25402 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2-3-0 unipri Due to for as a consequence of) 2-3-da Phinan-Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Accident Dichting Mellicas 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Dinen completion of ceuse of death? 1 Tyes 2 No.

Physician /Medical Examiner

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ir than "natural", or items 23s or the Medical Examiner must be

e filed within 72 hours efter al Hygiena.
other than "natural", or ite

permit. Pages 1 end 2 should be fill Department of Health end Mental Hill Important: If Item 27 Is marked othen any Injury or other traumstic even

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Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thaf initiated events resulting In death) Last

teno relevatio Cardinarche

25. Was cese referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury ef Work? 1 Matural 5 Pending

1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier 1 🖰 Certifying Phyaician: To fhe best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

APRIL 18, 1999 018019

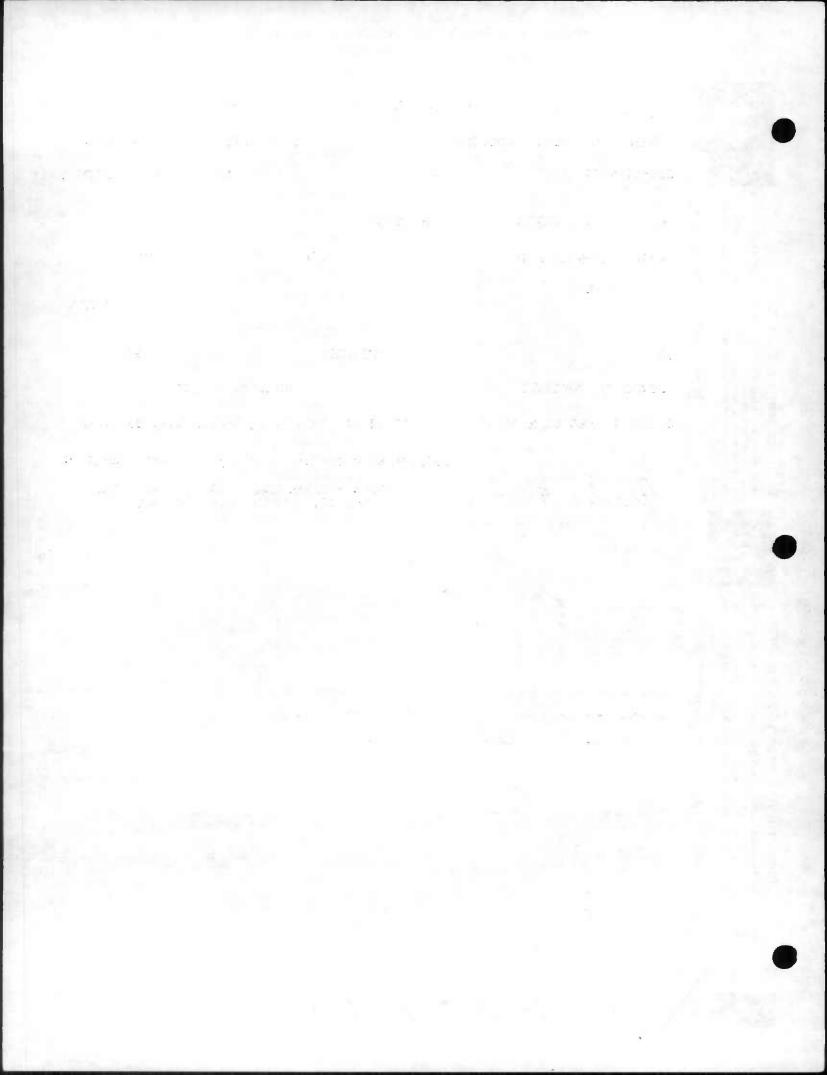
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- Water Mo

DR. V. DATTA, 334 MILL STREET, HAGERSTOWN, MD 21740 31. Date filed (Month, Day, Year) APR 2 0 1999

Registrar

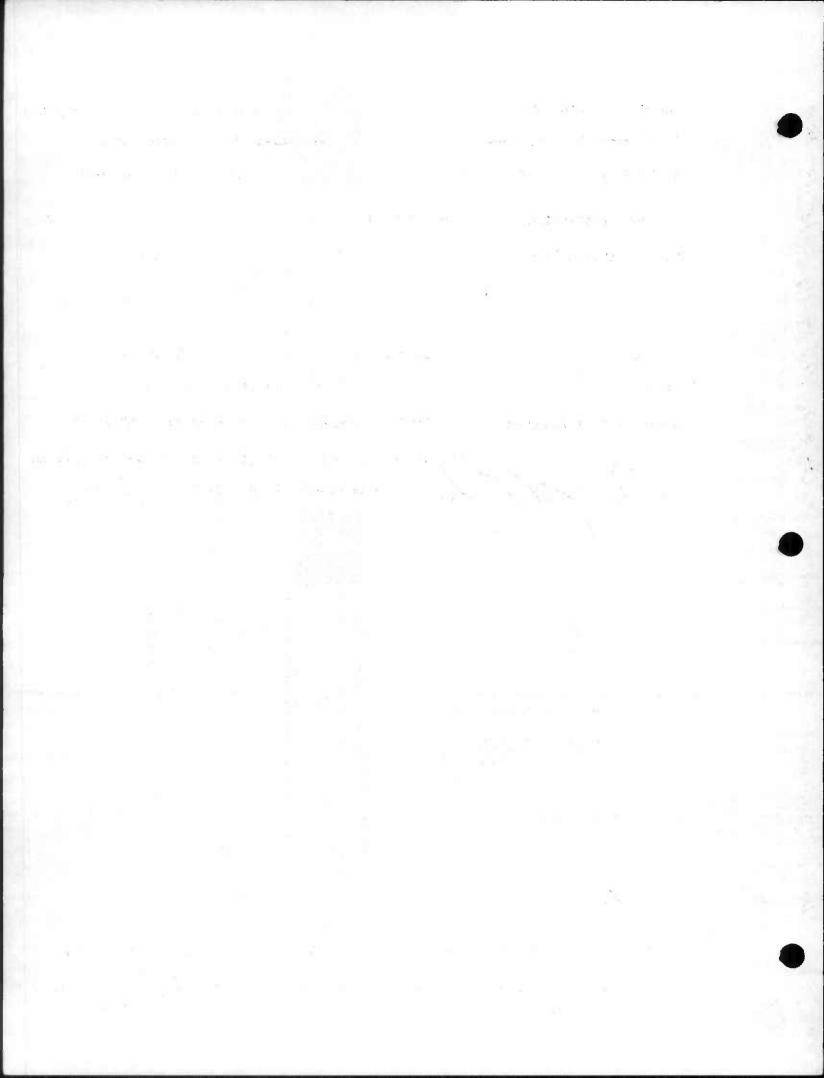
32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

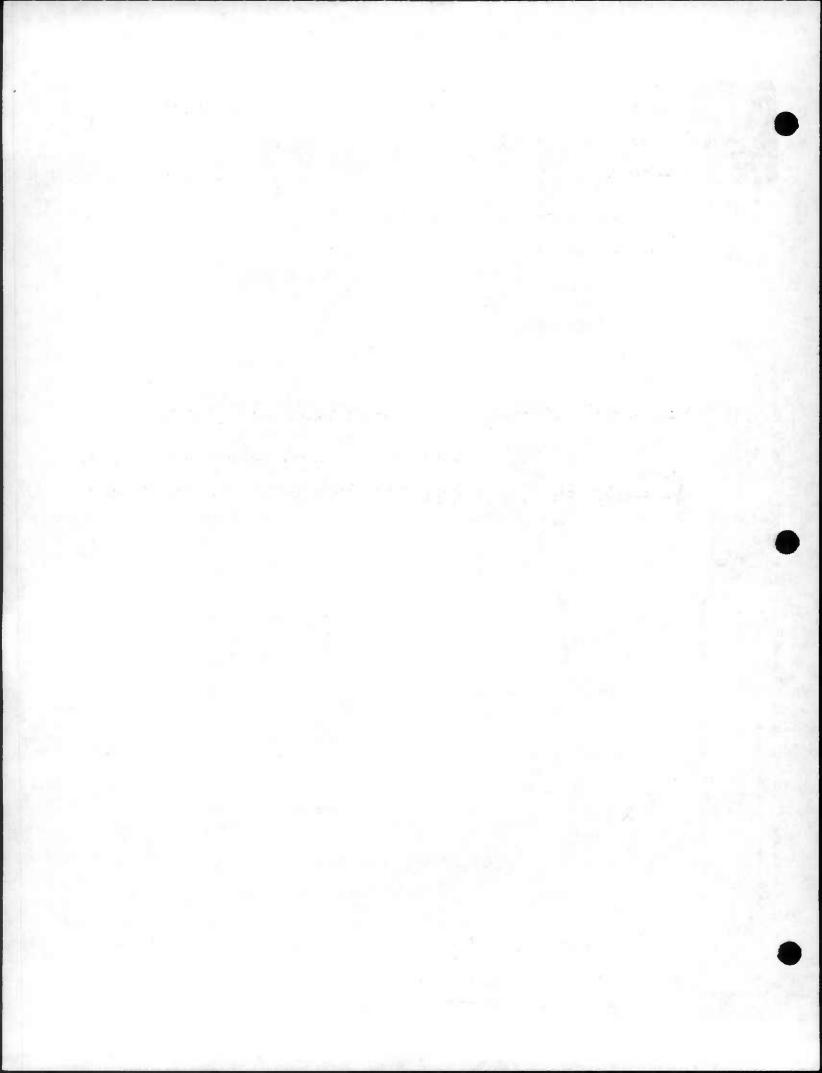
State of Maryland / Department of Health and Mental Hygiene

Physician /Medical Examiner		Decedent's Neme (First, Middle, La	st)	001	rtificate of		2. Dete of De	Reg. No. eth		3. Time of Death	
		Anna Rebecca BARN					Month	Dey	Yeer	10 45 4	
		4e. Fecility Neme (If not institution, give				4b. City, Town, or Lo		7,1999 4c. County	of Death	10:45 A.I	
		Williamsport Nurs	and the second s			Williamsp			ingto	on	
Funeral		Sociel Security Number 6. 8		. lest birthdey)	If Under 1 Year	If Under 24 Hrs.				liece (State or Foreign	
Director		217-10-3195 Usuel Residence of Decedent	□M 2⊠F 83	Yrs.	Months Deys	Hours Min.	8. Dete of Bir (Month, De July 1	, 1915	Mary	(and	
with the Maryland a or 28a-f show be notified at Director		10a. Stete 10b. County	10c. C	ity, Town or Lo	cation				1	0d. inside City Limits	
		Maryland Washing	gton	Hagers	town					1 ☐ Yes 2 💢 No	
		10e. Street and Number			10f. Zip Code			10g. Citizen of	Whet Cour	ntry?	
The wife	D	9624 Downsville F	Pike		217	740	40				
r flems 23 niner must		11. Meritel Status	12. Wes Decedent Ever in Armed Forces?	J,S. 13.	Wes Decedent of I	dispenic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	- 14. Rac	e - Americ	an Indien,	
"natural", o adical Exar	1 ☐ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No if Yes, Give Year or Detes:		1 ☐ Yes 2 No	Specify:	rican, etc.)		ck, White, /: Whi			
	ted	15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of work done during most of working							d of Business/Industry		
	ple	Elemantary/Secondery (0-12)	d) d) d)	working							
the part	O	8	College (1-4or 5+)	Carr	ier			Newsp	aper		
Be some		17. Fether's Neme (First, Middle, Last,				18. Mother's Nem					
		Alfred E.	Dick			Ella Eli	zabeth	Barrett			
Dan B		19e. Informent's Neme/Raietionship (-	end Number or Rur					
permit. Pages 1 and 2 about popurnoen of Health and Mer important: if them 27 is marked any injury or other traumatic place.		Carmen Canfield/			<u> </u>	dstown Pi					
		20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐	Removel from State	cemetery, crer	sition (Neme of netory or other ple		Dete	20c. Location -			
ant: I		4 □ Donetlon 5 □ Other (Specif	(Gr	eenlaw	n Mem. Pa	ark Apr.20),1999	William	spor	t,Maryland	
Departr Imports any inju		21. Signature of Funeral Service Licer	2/ Ol	0:	Name end Addression Fu	ess of Fecility Ineral Hon				_	
-		23a. Pert1. Enter the disease, or com shock, or heert feilure. List only	plications thet caused the dee	oth. Do not ent	er the mode of dvi	na, such es cardiec	or respiratory e	liamspor mest.	T,MU		
hysician		shock, or heart feiture. List only	one ceuse on eech ilne.		,		,	,		Approximete Interval Between Onset and Deeth	
/Medical		Immediete Cause (Fine	D						į	2 - 45	
xaminer		disease or condition rasulting in death)	. Preum							2 weeks	
	ē			or es e consec					į,	LOOKS	
physician and s the burial-transit	edical Examiner	Convention list and disease	b. Alzheim		Diseas-	<u>e</u>			1	yeas	
physician and is the burial-transit	EX	Sequentially list conditions, if eny, leading to immediate causa. Entar Underlying Ceuse (Diseesa or injury c.									
ysicie e bu	cal	thet initiated events									
0.6		resulting in deeth) Last	500.00	01 40 0 0011464	uonoo ory.				i		
andin use	Ş	•	d						i		
d for	Cla	Pert ii. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause di	ven in Pert i	23h Did	tobacco usa co	ntribute to	the causa of death?	
by th	hys		_	-		out to		Yes 2 No		bably 4 Unknown	
ped e	by Physician/M	Congestive He	art tailu	re				2/2010			
been signed by the attending should be detached for use a	Pa						24a. Wes	an autopsy	24b. W	ere autopsy findings	
sho	Completed						perfo	med?	co	allable prior to mpletion of cause death?	
certificate hes rector, page 2	E C						10	Yes 2000			
ficati		25. Wes case referred to medical						1	10	Yes 2□ No	
certi	o Be	examiner?	Hospitei:	Jenio	Otl	26. Place of Deet			50 125000		
n. After this certificate hes been signed by the attendin funeral director, page 2 should be detached for use	: To	27. Menner of Deeth	1 ☐ inpatient 2 ☐ 28e. Dete of Injury	JER/Outpatien 28b. Time of	T 3LI DOA	4 Nursing Ho		dence 6 LJOth how injury occur		y)	
After fune	tor	1 Natural 5 Panding	(Month, Day Year)	Injury	Wo	rk? Yes 2 □ No		,,			
efter death. Director: After	Certification:	3 ☐ Suicide 8 ☐ Could not b	28f. Location (Street and Numb	per or Rura	al Route Number.					
Direct In Direct	erti	4 ☐ Homicide determined	28a. Piece of injury - At I building, etc. (Spec	City or To		0, 0, 1,0,0	, riosto resimpor,				
ours filled		29a, Certifier Certifying Ph	ysician: To the best of my kn	nuledne deeth	occurred at the ti	me date and niece	and due to the	cause(s) and m	20007 88 6	lated	
within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical		niner: On the basis of examin end menner stated.	etion end/or inv	estigetion, in my	opinion, deeth occur	red et the time,	dete end piece,	end due to	the cause(s)	
within 24 hours of To the Funeral Completely filled	Me	29b. Signature end title of certifier	one months states.		29c. Licens	se number	1	29d. Date signe	d (Month.	Dev. Year)	
s F ö			uther - of -	d 0	747	451					
		20 Name and address in		79 110	V F (101		april	acu,	, , , ,	
		30. Nema end eddress of person who Cynthia Kuttne 31. Dete filed (Month, Dey, Year) APR 2 0 199	completed cause of death (ite	m 23a) (Type,	erint)	Camerie	Pd S	uite 131		// / ^	
-01	40	31. Dete filed (Month, Day Year)	32 Hanistrate Sinn	11(10)	rearcal	Chiripus	Va. Ha	agerst	own ,	Maryland	
Sta		APR 2 0 199	39	Ø.	Spark	2/		- oc	116		
Registr	ar 1	144 11 19 D 1		/	/ /						



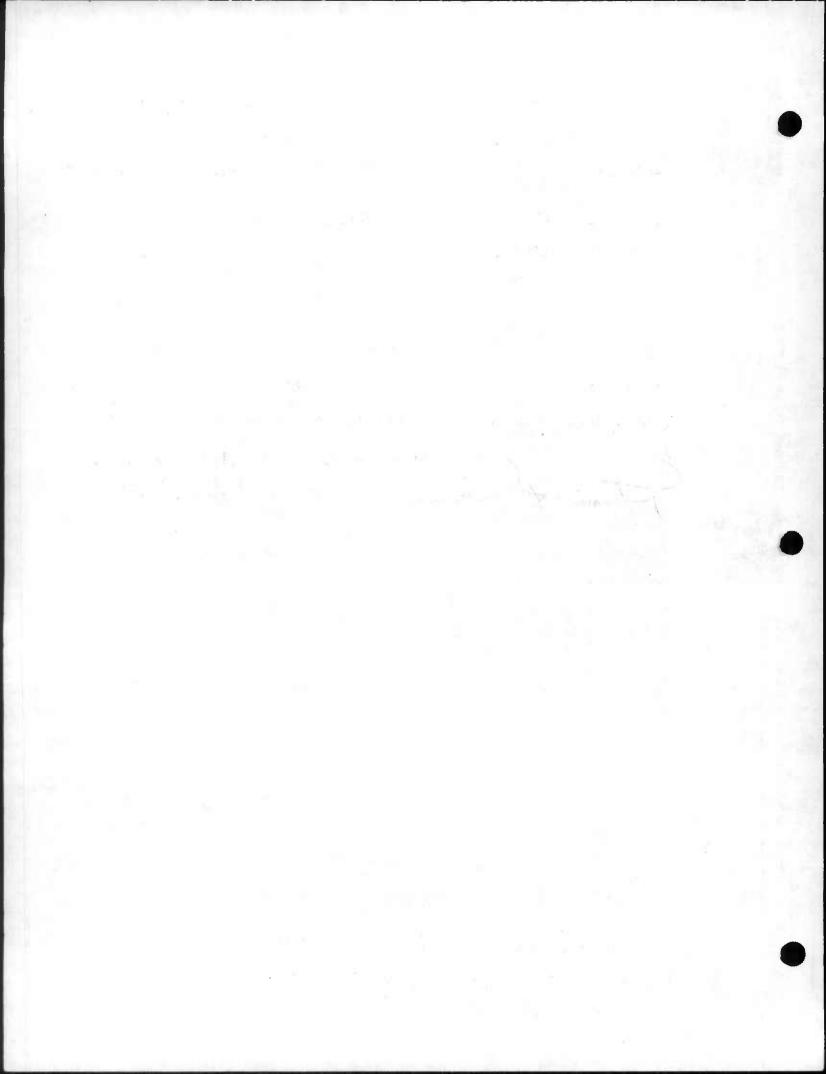
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Daath Month **Physician** Joseph Sebastian Belin Apr.17,1999 6:45 PM /Medical 4a. Facility Nama (If not institution, giva straat and numbar, 4b. City, Town, or Location of Daath 4c. County of Death Examiner Colton Villa Nursing Center Hagerstown Washington If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 6. Sax 9. Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) .Funeral 8. Data of Birth (Month, Day, Yaar) XXM 2 F Months Days Hours Yrs. Director 194-01-9945 Aug. 15, 1907 Pa Usual Residence of Decedant permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Merital Hygiene. Important: if item 27 is merked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, in Medical Experiment. 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Washington MdDirector Hagerstown 1√2 Yas 2 No 10e. Street and Numbar 10f. Zip Coda 10g. Citizen of What Country? 402 Cornell Ave 21742 USA Funeral 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yas 2☐ No If Yas, Give* Yaar or Datas: Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Navar Married 2 Married Specify: White 1 ☐ Yas 2 No Spacify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) Mill Wright Cement 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Paul Belin Vancas 2 19a, Informant's Name/Ralationship (Type, Print)
Ralph J. Belin, Jr./Grandson 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 404 Cornell Ave. Hagerstown, Md. 21742 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata Riverview Mem. Park, Inc. 4/20/99 Penn Hills, Pa. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funaral Sarvice Licensee 22. Nama and Address of Fecility Burner Trade Services 1037 Dual Place, Hag. Md. 2174D DWENEY, MBTE 23a. Part1. Enter tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cerdiac or raspiratory arrast, shock, or haart failura. List only ona cause on aach lina. Approximata Intervel Between Onsat and Daath Physician Immediata Causa (Final disaesa or condition resulting In daath) /Medical LUNG CANCER 4monta Examiner Dua to (or as a consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificete be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Sequantially list conditions, if any, laading to immadiata ceusa. Enter Undarlying Ceusa (Disaasa or Injury that initiated avants rasulting in daath) Last bunial-tran Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician X Physician/Medical the Dua to (or as a consequance of): ate hes been signed by the attending page 2 should be detached for use es × Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yas 2 ☐ No Be Completed by 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was en eutopsy performad? this certificate 1 Yas 2 No 1 Yas 2 No director, 25. Was casa rafarrad to madicel axaminer? 26. Pleca of Daath (Chack only one) 1 Yas 2 No Certification: To Othar: Surring Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Natural 5 Panding investigation 1 Yas 2 No 2 Accidant filled in by the 6 Could not ba datarminad 3 Suicida 28e. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 28f. Location (Streat and Number or Rural Routa Numbar, City or Town, State) 4 Homicida within 24 hours a To the Funeral D completely filled 29a. Cartifiar (Check only one) 12 Certifying Physician: To the bast of my knowladga, daath occurred at tha time, data and place, and dua to tha causa(s) and menner es stated. Medical 2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) end menner stated. 29b. Signature and titla of certifiar 29c. Licansa numbar 29d. Data signed (Month, Day, Yaar) . augar D28365 30. Nama and address of person who complated ceuse of daath (Itam 23a) (Type, Print) MANZAR JSHAFI 368 MILL STREET HAGERSTOW MD 21790. 31. Data filad (Month, Day, Yaar) 32. Registrar's Signature State APR 1 9 1999



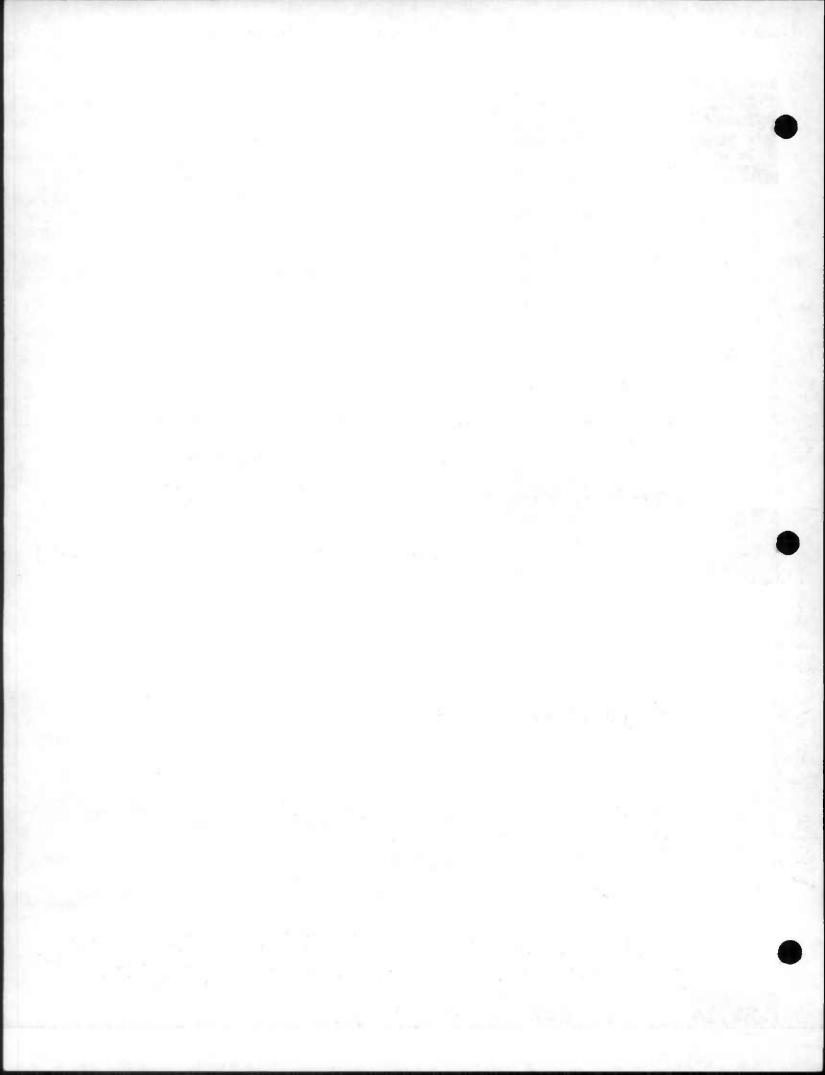
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Jane Barger April 5:00 A.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13632 Wolfsville Rd. Smithsburg Frederick If Under 24 Hrs. 8. Date of Birth 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Marykana **Funeral** Hours Months Days 72 218-24-1593 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits 7 is merked other than "natural", or items 23s or 28a-f shov traumatic event, the Medical Examinal must be notified at Director Md. Frederick 1 ☐ Yes 2 No Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13632 Wolfsville Rd. 21783 238 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Intit if fam 27 is merked other than "naturat", or items 23 intit if fam 27 is merked other than "naturat", or items 23 into other traumatic event, the Medical Exam mermatic. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White b 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Hame 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Hubert Wolfe Della May Lewis 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Alfred H. Barger (Husband) 13632 Wolfsville Rd. Smithsburg, Md. 21783 20b. Place of Disposition (Name of cometery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from Department of important: If any injury or Mt. Bethel Cemetery April 19,1999 Foxville, Md. 21 Signature of Furieral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Part. Enter the disease, or complications that ceused the death. Denot enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examine years_ Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, Coliessur Physician/Medicai Due to (or as e consequence of ate has been signed by the e page 2 should be deteched f Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dld tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ Be Completed 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of ceuse of death? certificate 1 Yes 2 No 1 ☐ Yes 2 Z Ne or Attending Physician: 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) Medical Certification: To After this in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Destitying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier end manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. 30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print) MILL HAGERSTOWN 31. Dete filed (Month, Day, Year) State Registrar



	_						Cen	iticat	e or	Death			Reg. No.				
Physicia /Medic		1. Decedent's Name (Fir Vi.		Grace	Benn	nett						2. Dete of D	13. Day	L999	Yeer		e of Death 5 a.m.
Examin	_	4a. Facility Name (If not a Julia Ma	nor H	nor Health Care Center						4b. City, Town, or Location of Death Hagerstown				Washingto			
Funeral Director		5. Sociel Security Number 218-30-8923						If Under Months	1 Year Deys	If Under Hours	24 Hrs. Min.	8. Dete of B	b, 19	09	9. Birthp Coun Penn	olece <i>(Sta</i> htry) ISYIV	te or Foreign ania
Marylend -f show	tor		. County	nington 10c. City, Town or Location Boonsbore)						10d. Inside City Limits 1 ☐ Yes 2√2 No		
r 28a	rec	10e. Straat and Number						10f. Zip	Coda				10g. Citi	zen of V	Whet Cour	ntry?	
h witi	ai D	19327 Betty's Avenue 217							713				USA				
Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hyglens. Important: If flam 27 is marked other than "patural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Maritel Status 1 ☐ Naver Married 3 ☒ Widowed 4 ☐ I	ar in U,S.		as Deced Yes, spec		lispanic Or an, Mexica Specify:		pecify Yas or N Rican, atc.)	0-		k, White,	marican Indien, hite, etc. White				
5-0 72 ho	ted	15. I	Decedent's	Education greda completad		16e.	Decede	nt's Usue	ol Occup	etion during mos d)	t of work	kina	16b. Kii	nd of Bu	usiness/Inc	dustry	
/ithin	Be Completed	Elementary/Secondary	, ,		1-4or 5+)				se retire	d)		9					
d 2.	ပ္ပ	17. Fethar's Nema (First, Middla, Last)					Cle	rĸ		19 Moth	or'e Nam	J. J. New				berry	
yland hould be f I Mentel herked of matic even	To Be	Marshall		Hollada						Armir	nta		Ri	inge	r		
and 2 st auth and 27 Is m		19e. Informant's Name/F Rheda	Reese		Daugh	iter 193	_					ral Route Numi Boonsbo					L3
Or oth		20e. Method of Disposition 1X Buriel 2 □ Cre		☐Removel from		20b. Plece of cemeter	Disposi y, creme	tion (Ner story or o	ne of ther pla	ce)		Data	20c. Lo	cation -	City or To	own, Stete)
Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours at Department of Health and Mariel Hyglens. Introorant: It item 27 is marked other than "natural; or any injury or other traumatic event, the Madical Examples."		1X Buriel 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Add. Gerald N.						d Addre	ss of Fecili	ity	/16/99 305 N	Hager				Land	
W &05 a a		Buch	01.0	Inns	NO	n	Fur	nera:	l Ho	me		Hager	stown			and	21740
Physician /Medical Examiner		23e. Part1. Enter the dis shock, or heart failt Immediete Cause (Final disease or condition resulting in death)		emplications that all one cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause of the cause	caused the each line.	1		the mod			cardiac	or respiretory	errest,			Approxi Intervel Onset e	meta Between nd Death
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oerificate be assocuted certificate be assocuted ding physician and use es the burial-transit	/Medical Examiner	Sequentially list condition if eny, leeding to immedicause. Enter Underlying Cause (Disease or injury	ns,	b	Du	ue to (or es e	consequ	ence of):									
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O. E daa the at the at	Physician	Pert II. Other significant	conditions	contributing to d	leath but r	not resulting in	the unc	derlying c	ause giv	en in Pert	I.	23b. Dlo	I tobacco	use co	ńtribute to	o the cau	se of death?
	Ph)	AL3H	5,11	er's	DI	SEA	se					1	Yes 2	No	3 Pro	bably 4	I 🗌 Unknowr
of Vital Records, P.O. Be Physician: The law requires that the death this certificate has been signed by the atternal director, page 2 should be detached for	ed by												s en eutop	sy	24b. W	ere eutop	sy findings
aw requir	Completed										<u></u>	pen	formed?		co	mpletion daeth?	
The law	E O											1□	Yes 2	No	1[Yes	2□ No
Vital I	Be (25. Was case referred to exeminer?	medical								e of Dea	th (Check only	one)				
Physic this co	2	1 ☐ Yes 2 No		-		2 ER/Ou		3□ DC		4 LUN	ursing H	ome 5□Res				fy)	
Vision of Vita Attending Physicien: art deeth. ector: After this certifics by the funeral director,	lon		Pending investigat		of Injury oth, Dey Y		ime of njury	M 2	8c. fnju		No	28d. Dascribe	how injur	y occur	red		
Division or Attending eftar death. Director: After	flcat		Could not	be on Die	e of Injury	/ - At home, fa	rm. stree						al Route I	Vumber.			
Div	Certification:	determined 4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							City or To	own, State)						
Hospi 4 hou Funer taly fill	edical	29a. Certifier 12 (Check only one)	Certifying I Medical Ex	Physician: To the aminer: On the band man	e best of ro	xaminetion en	, death o	occurred stigetion	at the til	me, date er opinion, dea	nd ptece, ath occur	, end due to the rred et the time	e cause(s) , date end	and ma	anner as s end due to	tated.	se(s)
To the I within 2 To the I complete	M	29b. Signatura end title o	of certifier	na	91				Licens 2	se number	23		29d. Det	e şigne	d (Month,	Day, Yes	38
		Name end eddress of	person wh	no completed cau	se of deal	th (Item 23a)	Type, P		la	e Co	(h)	us Ro	70	7-1	GEN 741	5-1	in
Stat		31. Date filed (Month, Da	y, Year)		Registrer's	s Signetura	4		,					,			
Registra	ar	APF	14	1999	No. of Street, or other		Ø.	14	DOLL	6/							

DHMH 16 Rev 6/95



amend 8 WCHD 4-22-99 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) ADY) 0047 Minnie Ellen Barrus 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Washington County Hospital Hagerstown Washington County If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days 1 □ M 2 0 F 78 Yrs. 071-14-1772 Canada 12,1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Co. 1X Yes 2 □ No Hagerstown 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code USA 1012 Washington Avenue 21740 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Stetus Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12 0 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Sylvia D. Crosset Colonel W. Ball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Nelson Barrus, Sr./Husband 1012 Washington Avenue, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cometery, crematory or other place)
Cedar Lawn Mamorial Park Apr.15 20c. Location - City or Town, State 20a Method of Disposition Hagerstown, Maryland 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 reucho Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Bitnocture ling disease Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequenca of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 ANatural 1 Yes 2 No 2 Accident Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Barrus, Minnie

/Medical Examiner The law requires that the deeth certificate be executed anding physician and use as the burial-tren Division of Vital Records, P.O. Box 68760 pege 2 should After this certificate has Hospital or Attending Physician: To the Hospital within 24 hours e To the Funeral Completely filled

Physician

/Medical

Examiner

Director

Funeral

g

Completed

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "natural", or Nems 23a or 28a-f show

altimore, Maryland 21215-0020

7 is marked other than "natural", or items 23a or 28a-f show traumetic svent, the Medical Examiner must be notified at

Important: It any Injury o

Physician

Physician/Medical Examiner

by

Completed

Be !

To

Certification:

Medical

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29d. Date signed (Month, Dey, Year)

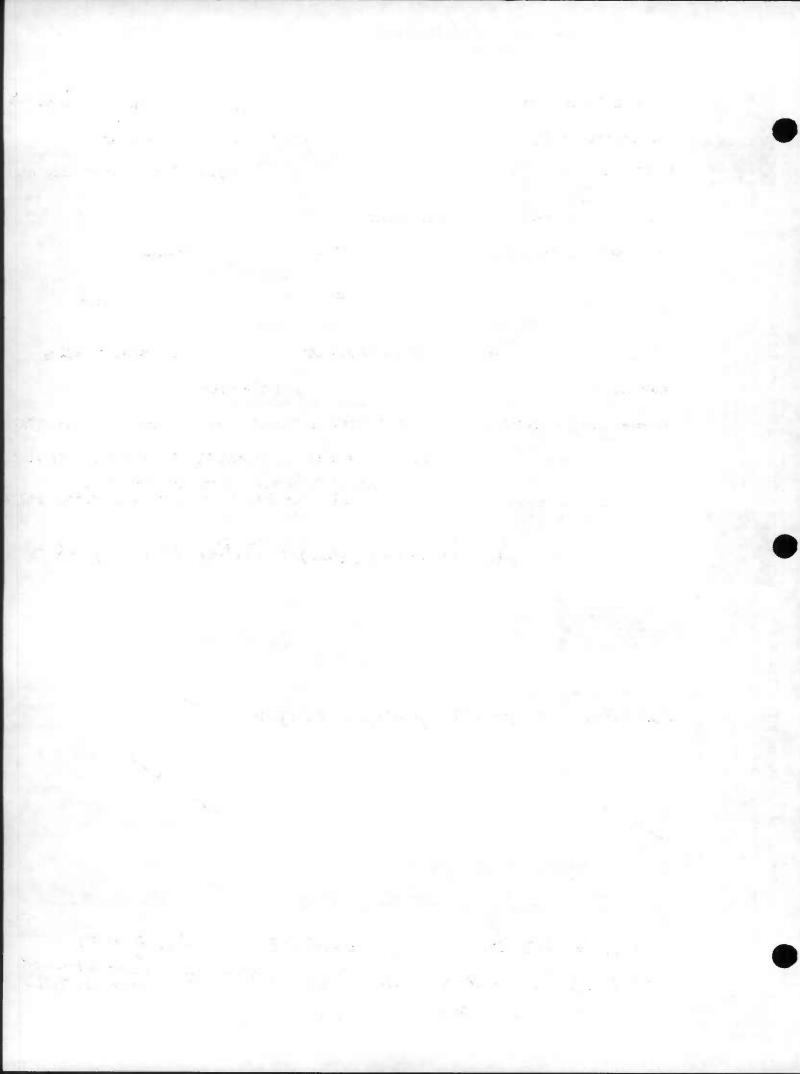
32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

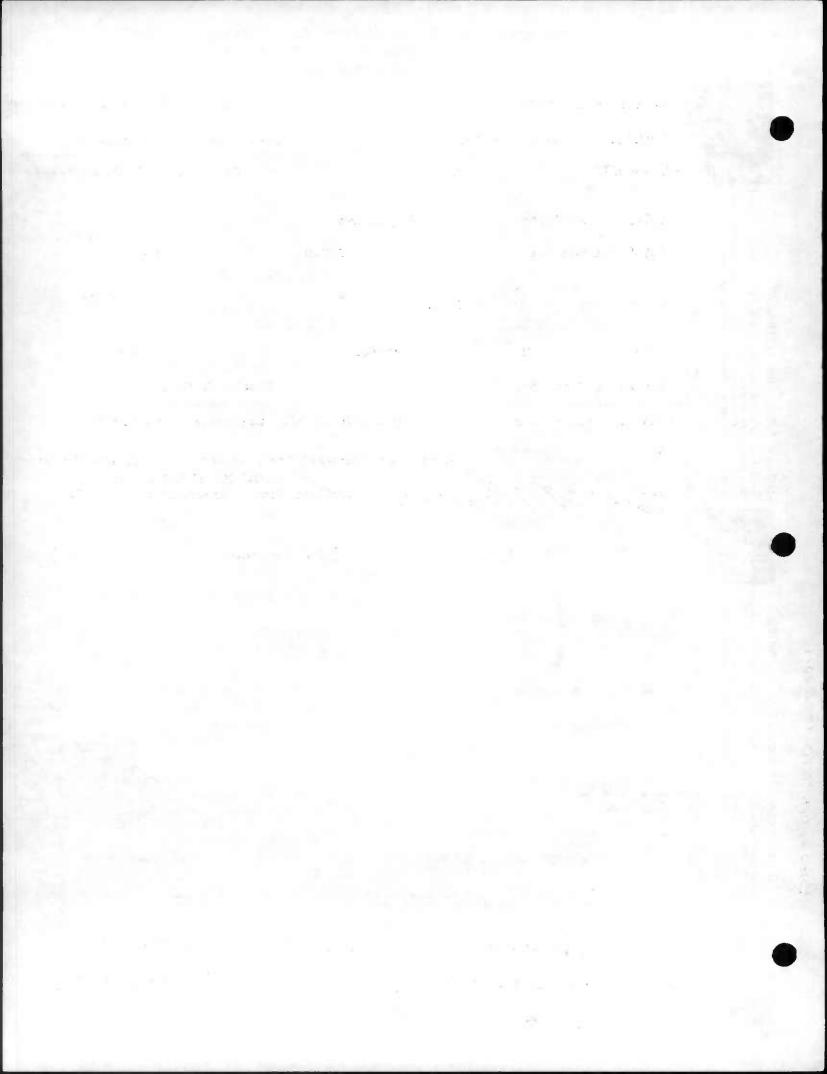
State of Maryland / Department of Health and Mental Hygiene 3 4 3 0 5

				Certificate of	of Death		Reg. No.			
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Maryland -f ehow	Usual Residence of Decedent 10a. State 10b. County Maryland Washingt		oc. City, Town o		П		10d. Inside City Limits 1%□ Yes 2□ No			
th with the Mar 23a or 28a-f e	10e. Street and Number 120 Cumberland St	reet		10f. Zip Cod 21	• 722		10g. Cifizen of What (U.S.A.	it Country?		
l A LA IS-OUZO led within 72 hours after death with the Maryland yighen. The Institute!, or items 28s or 28s-f show it, the Medical Examiner must be notified at Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	or in U,S.	13. Was Decedent If Yes, specify C 1 ☐ Yes 2 ☑ 1	uban, Mexica	igin? (Specify Yes or in, Puerto Rican, etc.)	city Yes or No- lican, etc.) 14. Race - American Indian, Bleck, White, etc. Specify: White				
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ie, Mar ylafia A. I.Z. s and 2 should be filed within thatil and Marail Hygiere. tem 27 is marked other than other traumatic event, the Mar	17. Father's Name (First, Middle, Last) James Cross		er's Name (First, Middantie Pric	dle, Maiden Sumeme)						
2 sho and I is me	19a. Informant's Name/Relationship (7)	rpe, Print)	19b. P	Mailing Address (Str	eet end Numb	er or Rurel Route Nur	mber, City or Town, Stete	e, Zip Code)		
	Carlene Staley, D 20a. Method of Disposition 1 XBuriel 2 Cremetion 3 CF	Removal from State	20b. Place of Cometery,	6 Cumberl Disposition (Name of cremetory or other Le Rose H	place)	Date	20c. Location - City			
Daltimore, permit. Peges 1 a Department of Has Important: If Nem eny Injury or othe page.	4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licens			22. Name and Ag Donald	dress of Facili		12 Clear Spring, Marylar neral Home, Inc. ar Spring, Maryland 2172			
Physician /Medical Examiner Examiner Examiner	23a. Rart 1. Enter the disease, of compishook, or heartoallure. List only of immediate Cause (Final disease or condition resulting in death)	a. Acu-	e to (or ss a co	40C JV		L Into		Onset and Death		
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ple 2 s 2					/		/as an autopsy enformed?	b. Were autopsy findings available prior to completion of cause of death?		
= = # 2 0	25. Was case referred to medical				26. Piac	te of Death (Check on	Yes 2 No	1 Yes 2 No		
T di di	examiner?	Hospital:	2 ER/Outp		Other: 4 N	ursing Home 5	esidence 6 Other (S	pecify)		
SION eath. or: After the fune	27. Menner of Deeth 1 Statural 5 Pending 2 Accident 3 Suicide 6 Could not be	28e. Dete of Injury (Month, Day Y		M	njury et Work? 1 □ Yes 2 □] No	be how injury occurred	Pural Paula Alumbar		
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To the within To the complex	29b. Signature and title of certifier	ne k		29c. Lic	ense number	3	29d. Date signed (M.) Au / 8, /	onth, Day, Year)		
,	30. Name and address of person who de Diru T. 170/1	ompleted cause of deel		ype, Print)	Pella	PAMAS	P4) . HAG	ERSTOUN 21742		

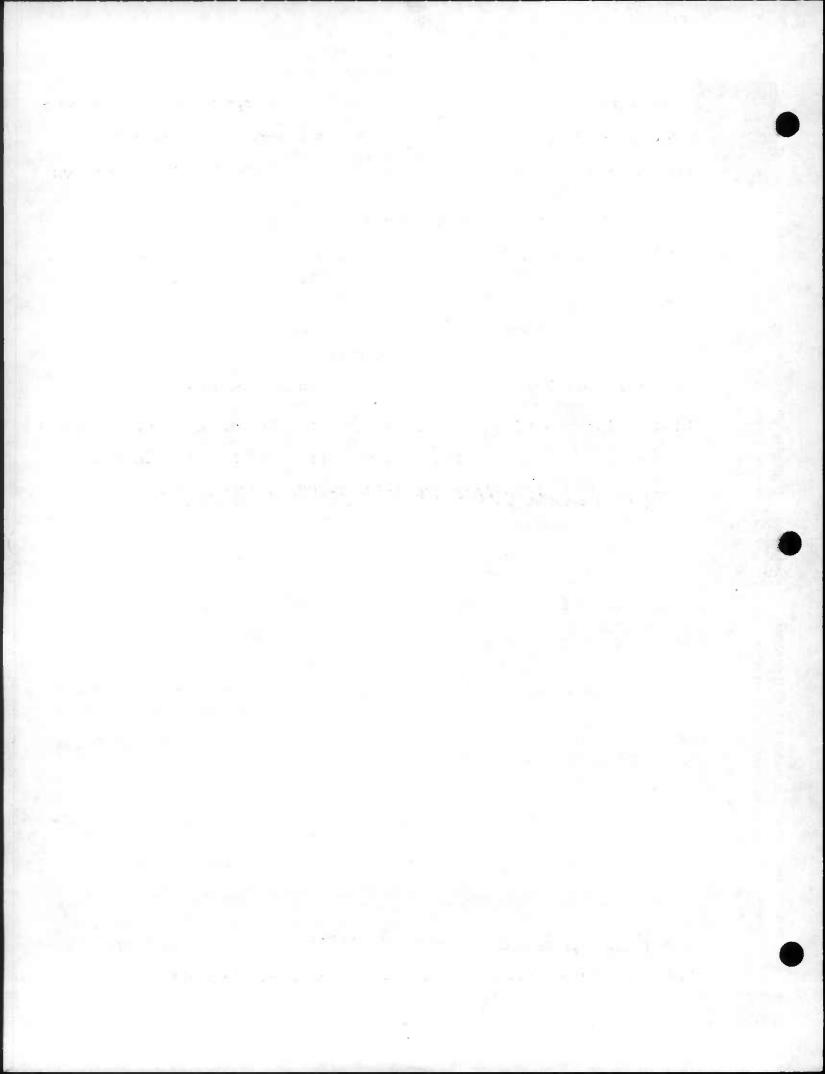
State Registrar



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	la Facility Name (If								cation of Deet		y of Death			
			unty Hosp		land historia	If Under 1 Ye		lager:			ton			
	5. Social Security Nu 207–14–63		6. Sex 12∑ M 2☐ F	7. Age (In yrs. 72	Yrs.	Months Day			8. Date of Bir (Month, Da Feb. 1			9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of			12					reb. 1		1611	nsylvania		
21	10a. State	10b. County		10c. Cit	y, Town or L	ocation					1	0d. Inside City Limits		
Director	Maryland	Wash	ington		Hage	erstown						1 ☐ Yes 2 ☒ No		
Dire	10e. Street and Num		D 1			10f. Zip Cod				10g. Citizen of		itry?		
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	1 ☑ Burial 2 ☐ 4 ☐ Donation		3 □Removal from ecify)	State		wn Memo:		ark	4-10-9	9 Hage	rstow	n,Maryland		
	21. Signature of Fur	peral Service L	icensee	1		2. Name and Ad								
	15	CA DO	nn	mun	4	415 E.W						21740		
	23a. Part1, Enter the shock, or hear	ne diseese, or t failure. List	complications that only one cause on	ceused the deet each tine.	h. Do not en	iter the mode of	dying, such a	s cerdiac (or respiratory (errest,		Approximate Interval Between Onset and Death		
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ner				230.00										
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odlo	Cause (Disease of Injury that initiated events resulting in death) Last Due to (or es e consequence of):													
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Fune Direct		579	el Security Numb $-14-03$ Residence of Dec	13	Sex I□M 2【X F		n yrs. lest biri 78	thdey) Yrs.	If Under Months	1 Year Deys		Min.	8. Date of Birth (Month, Per lay 26	1920	9. Birth Cou Ma	nplece (Stete or Foreign intry) 1 Tyland	
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th with th	Director	10e. St 28	reet end Number 04 Meri	ritt M	Mill R	oad			10f. Zip		804			10g. Citizen <i>o</i> f US		intry?	
15-0020 72 hours efter death with the Maryland 72 hours efter death with the Maryland 7-netural', or items 23e or 28e-7 show	hy Europe	3K	ritel Status Never Married Widowed 4		12. Wes Dec Armed F 1 Yes It Yes, G Yeer or I	orces? 20 No live	or in U,S.				Hispenic Or ben, Mexice Specify		ecify Yes or No- Rican, etc.)	14. Ra Ble Specil	ck, White	ican Indian, , etc. nite	
			(Specify or	-	ducetion ade completed)	16e.	Decede (Give k	ent's Usue ind of wor	el Occu rk done	petion during mos	st of work	ing	16b. Kind ot B	lusiness/li	ndustry	
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Dallimore, pemit. Peges 1 er Department of Hea Important: If Item;	once.	21. Sig	Donetion 5 neture of Funera	Samoo Ug	1500	MA	Mt. R	22. A R	Name en	d Addr	ess of Fecili	ty	'26/99 FUNERAI	HOME	РΔ		
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Examin	i j	resultir	e or condition ag in death)		e		e to (or es e o			.010	J11					7 years	
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The law ata has b page 2 s	Com												1□ Y	es 2 No		☐Yes 2☐ No	
lcian: The certificata rector, pag	Be	25. We	s cese referred to miner?	medicei								of Deeth	(Check only or	ne)	1		
Physician: rthis certific ral director,	2	10	Yes 2 No			-	2 ER/Out		-	A			me 5 Resid			ify)	
The state of the s	Certification:	1	Accident	Pending investigetion	1	nth, Dey Ye		njury	М		iryet ork?]Yes 2∐	No	28d. Describe h			ral Route Number,	
is aftar al Direction by	Certi	4	Homicide	determined	build	ling, etc. (S							City or Tow	n, Stete)			
To the Hospital or Attend within 24 hours after death To the Funeral Director: A completely filled in by the f	edicai										enner es end due	steted. to the ceuse(s)					
To the To the Com	29b. Signeture/end title of certifier 29c. License number 29d. Date sign								ned (Month, Dey, Year)								
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Division of Vital Records, P.O. Box 68760,	F
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth **Physician** APRIL 19,1999 Maxine Runion Craven 5:35 AM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner It Under 1 Year If Under 24 Hrs.
Months Deys Hours Min.

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June 24, CIVISTA MEDICAL CENTER CHARLES 5. Social Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 20XF Months Yrs. 578-05-1989 Director 87 1911 Virginia Usuel Residence of Decedent 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Madical Examination must be notified at Yes 2 No Director Maryland Charles Indian Head 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 24 Highland Place 20640 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify: Specify: White Completed by Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within ment of Health and Mentel Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Her Home n Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Moward Ray Runion Lydia Biller 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Lester Craven Same as #10 or other 20b. Place of Disposition (Name of cametery, cremetory or other place) April 22, 1999 20e. Method of Disposition 20c. Location - City or Town, Stete XXBurial 2 Cremetion 3 Removel from State **Department** ortant: I 4 ☐ Donetion 5 ☐ Other (Specify) Trinity Memorial Gardens Waldorf, Maryland 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service License any in M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert fall rie. List only one ceuse on eech line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Cause (Final diseese or condition resulting in deeth) Examiner Examiner discase Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In deeth) Lest and SIN1.B Physician/Medical the Due to (or es e consequence of) 88 Pert II. Other significant conditione contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown confustin by 8 24b. Were eutopsy findings eveileble prior to Completed page 2 should 24a. Wes en eutopsy performed? completion of cause of deeth? certificate 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medicel 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To Impatient 2 ER/Outpatient 3 DOA After this funeral 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Naturel s efter death. 1 Yes 2 No 2 Accident in by the 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours of To the Funeral D Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) 29a. Certifier Medical end manner stated.

29c. License number

Contr

ted ceuse of death (Item 23e) (Type, Print)

ON lue

Snige 100 700

32. Registrar's Signeture

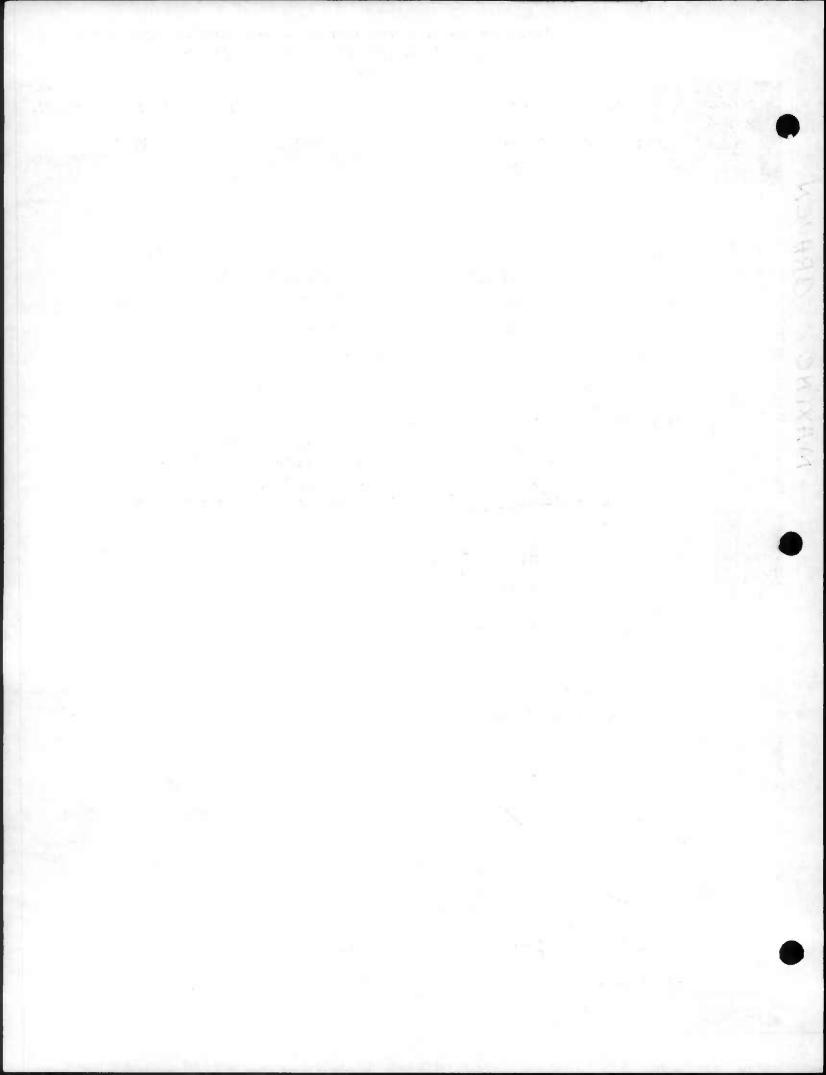
Colyner

29d. Dete signed (Month, Dey, Yeer)

Waterf IN 20602

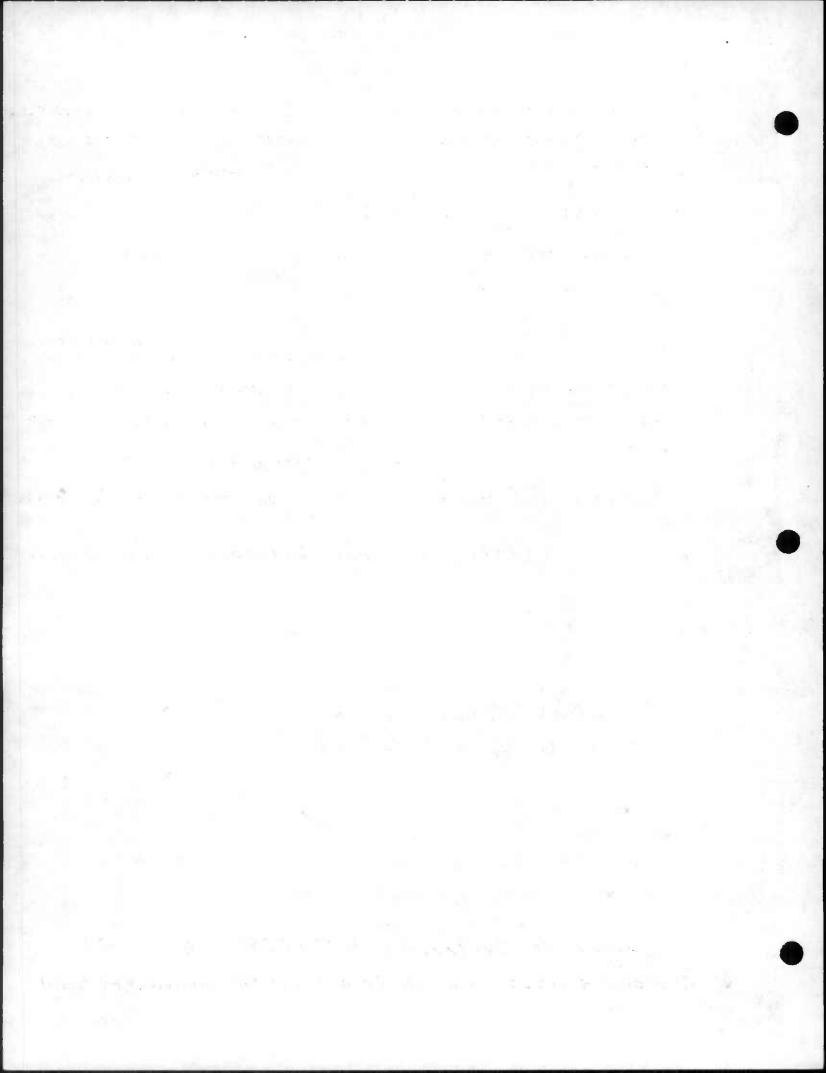
State Registrar 29b. Signeture end title of certifie

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 9

					Ce	runcate of	Deam		Reg. No.				
Physic	ian	Decedent's Name (First, M.	liddle, Last)					2. Date of De Month	eath Day	Year	3. Time of Death		
/Medi	cal		Dryden	Cathel	1		41- 01-	4 -		9	1:00 P.		
Exami	ner	4e. Fecility Name (If not instit					4b. City, Town, or I						
		Hartley Ha			4 ft 7 aft of - 1	If Under 1 Year	Pocomo		-	cest			
Funeral		5. Sociel Security Number 219-36-7244	6. Sex 1 ☐ M 2 ☐ MF	7. Age (In yrs. Id 94	as <i>t birthday)</i> Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, De 9-5-0	th ay, Year)		ace (State or Foreign		
Director		Usual Residence of Deceden						9-5-0	14	Mar	yland		
dand ow		10e. State 10b. Cou		10c. City	, Town or Lo	ocation				10	Od. Inside City Limits		
Man	ţ	Md. Wo	rcester	S	now E	ill					1 ☐ Yes 24 ☐ No		
r 28s	Te C	10e. Street end Number				10f. Zip Code			10g. Citizen of	What Count	try?		
3a o	0	7040 Public	Landing	Road		218	363		U.S	.A.			
should be filed within 72 hours after death with the Maryland end Mental Hygiene. The medical strength of them 23a or 28e-f show aumatic event, the Medical Examine must be notified at	Funeral Director	11. Marital Status	12. Was Dec	cedent Ever in U,S	S. 13.	Wes Decedent of I	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No)- 14. Rad	ce - America			
after or Ite	F	1 Never Married 2 !	Armed F Married 1 ☐ Yes	2 No ive				o Rican, etc.)		ck, White, e			
rai',	Completed by	3 🖫 Widowed 4 □ Divor	ced Year or I	Dates:		1□ Yes 2√2 No	Specify:		y: W	hite			
72 hours "natural",	etec	15. Dece (Specify only hi	dent's Education ghest grade completed)	16a. Dece	dent's Usual Occup	pation during most of work	kina	16b. Kind of B	usiness/Ind	lustry		
ithin ne.	du	Elementery/Secondary (0-1		(1-4or 5+)	life.	DO NOT use retire	d)	ung	Worce	ster	County		
led w lygier lygier th		11	4		edu	cation/	teacher				ucation		
be find H dot	Be	17. Father's Neme (First, Mide					18. Mother's Nan			ne)			
should be filed within and Mental Hygiene. Transkad other than irratic event, the M	2	Robert Edg		1				an Bat		(Dry			
		19a. Informant's Name/Relati					and Number or Ru		_				
other to	Ruth D. Yo	ung (Niec				Landin	_			Md.21863			
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremati	on 3 Removal from	0.0	metery, crer	sition (Name of metory or other pla	ce)	Date	20c. Location	- City or Tox	wn, State			
tment tant:	permit. Pege Depertment of Important: If any injury or office.	4 □ Donation 5 □ Othe		Wha	atcoa	t Meth. Ceme.4/17/99 Snow Hill, Md. Name and Address of Facility							
ermil eper npor ny in		21. Signature of Funeral Serv	rice Licensee		P.O.	Box	87						
70 = 8 Q		Valrice	a d. De	Funera	1 Home	, Snow	Hill	,Md.2186					
		23a. Part1. Enter the disease shock, or heart failure.	, or complications that	caused the death.	. Do not ent	er the mode of dyin	ng, such as cardiac						
certificete be executed uding physicien end use es the burlel-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Last	b	Due to (or	as a consequence of c	quence of):							
ath certif strending for use e	Physician/Medical	Part II. Other significant cond	d	seath but not resul	Iting in the u	nderlying cause giv	ven in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of death?		
thet the de led by the e deteched	Phy	Casen	tial &	1 /	-				Yes 2 No		ably 4 🗆 Unknown		
res the signer	by	0		2/1		Block	,						
w requires the been signed I should be det	Completed	Comp	lete &	Lear	11/	Slow	le	24a. Was	an eutopsy ormed?	eve	re eutopsy findings ilable prior to apletion of cause		
hes b	ldu			,						of d	leeth?		
	ပိ							10	Yes 2/1 No	1 🗆	Yes 2 No		
Physiclan: The this certificate ral director, peg	Be	25. Was case referred to med examiner?				100	26. Place of Dea	th (Check only o	one)				
Physical direction	2	1 ☐ Yes 2 ☐ No 27. Menner of Death		-	R/Outpetien		4 Mulising H		dence 6 □Oth)		
Ing After une	Certification:	1 Matural 5 ☐ Per		of tnjury oth, Day Year)	28b. Time of Injury	. Wor		28d. Describe	how injury occur	red			
F 8 5	Ical	3 Sulcide 6 Cou	estigation uld not be	a of Injury - At hon	no form str		Yes 2 □ No	28f Location /	Street and Numb	or or Burni	Pouto Number		
or A Dirac in b	arti	4 ☐ Homicide det	ermined 286. Place build	e of Injury - At hon ling, etc. <i>(Specify)</i>	ile, iaim, sui	eet, ractory, onice		City or To		HI OI MUIAI	noute runiber,		
To the Mospital or Atte within 24 hours after de To the Funeral Diracto completely filled in by the	Medical Co								place, and due to the cause(s) and manner as steted.		eted. the cause(s)		
o the	Me	29b. Signeture and title of cert		7)		29c. Licens	e number		29d. Dete signe	d (Month. D	Day, Year)		
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		30. Name and address of pers	200 11.	acco	000) (T	1	-110		7 -13	, - 7	-/		
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	10	GREGORIO N. 31. Date filed (Month, Day, Ye	ar) 30 F	Registrer's Signatu	750 A			VOK., 3A	LISBUL	(), MJ	1 71801		
Sta Registr	ar	31. Date filed (Month, Day, Ye APR 1	6 1999	aglstrer's Signatu	19.	Spark	2						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month . **Physician** LILLIE MAE CAREY 1312 april 1999 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Ments, Dey, Year) 23 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** 1□ M 2□ F Days 218-20-2820 ATTANTIC, VA. Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examinar trait to notified at WICOMICO Director MD. 1 ☐ Yes 2 ☐ No SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of Whaf Country? 1701 JERSEY ROAD 21801 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Y Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: AFRO-AMERICAN 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 72 th end Mental Hygiene. 7 Is merked other than "ne Elementery/Secondary (0-12) College (1-4or 5+) DOMESTIC HOUSEKEEPER 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) ELIJAH ROBERT EVANS FLORENCE AGNES MATTHEWS 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Department of Health or Important: If Item 27 Is any Injury or other treus SANDRA NORWOOD P.O.BOX264, PINE FORGE, PA.19548 Pages 1 20e. Method of Disposition 20b. Place of Disposition (Neme of 20c. Location - City or Town, State SPRINGHILL MEM. GARDENS 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4-17 HEBRON, MD. 4 Donation 5 DOther (Specify) 22. Name and Address of Facility JOLLEY MEMORIAL CHAPEL 21. Signature of Funeral Service Idean 1213 JERSEY ROAD; SALISBURY, MD. 21801 23a. Part 1. Erfet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, of heart failure. List only the cause of each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) · Arterioselerotie Coronary Arter Disease Examiner Physician/Medical Examiner Unstable angina physiclan and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☑ Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 4No 1 □ Yes 2 □ No 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred I or Attending P setter death.
I Director: After I d in by the funer. After 1 ANATURAL 5 Pending Investigetion 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide • Funeral Dire Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 02038 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Salisbury MD

State Registrar

Blatt

APR 1 6 1999

31. Date filed (Month, Day, Year)

Rd

wite

32. Registrar's Signature

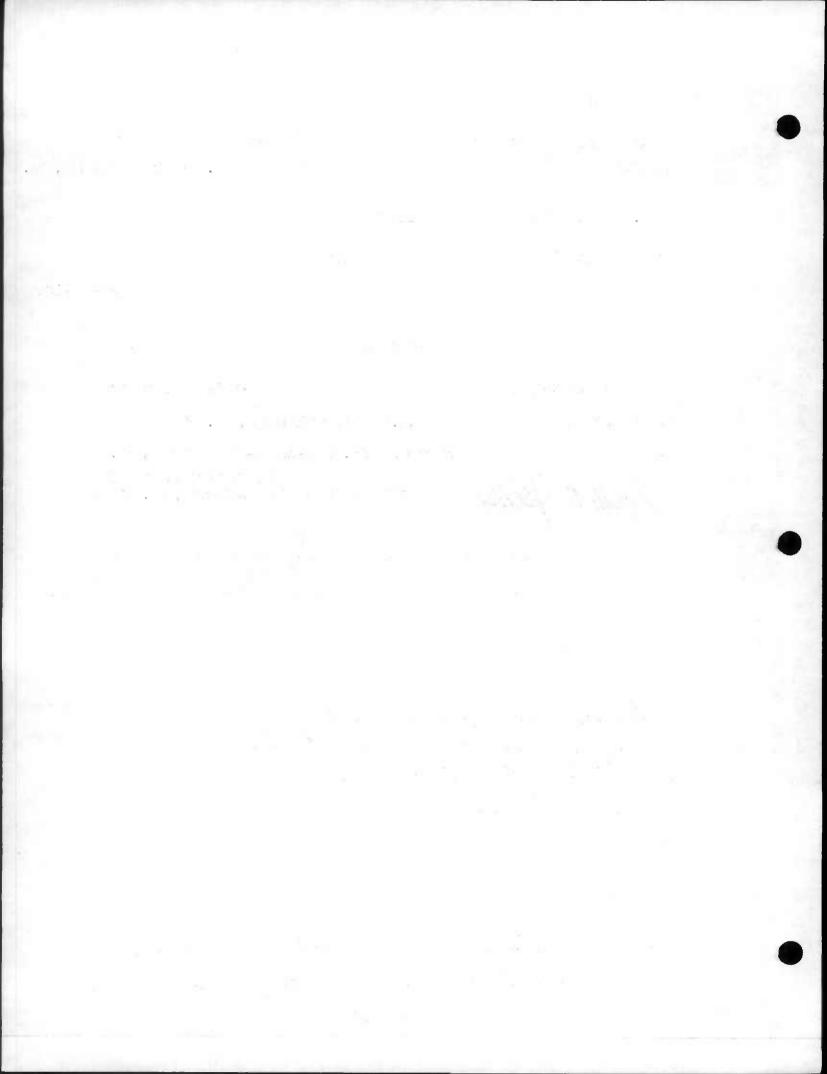
Maryland 21215-0020

Baltimore

Box 68760,

Division

- 20



Months

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last)

Physician	
/Medical	
Examiner	

JAMES

10a Stete

5. Sociel Security Number

236-70-9108

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

10b. County

PENINSULA REGIONAL MEDICAL CENTER

6. Sex 1 M 2 □ F

Funeral Director

the Maryland 28a-f show Examiner must be notified at ŏ Items 23a "natural", or

Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 21801 8859 Jersey Rd. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours efter 1⊠Yes 2□No If Yes, Give Year or Dates:Viet Nam 1 ☐ Never Married 2X Married Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "r any Injury or other traumatic event, tra Med any Injury or other traumatic event, tra Med any Engles. Elamantary/Secondary (0-12) Collage (1-4or 5+) Minister 12 17. Father's Name (First, Middle, Last) Be Forrest William Cain 19a. Informant's Name/Relationship (Type, Print) 8859 Jersey Rd., Salisbury, MD 21801 Wendy F. Cain/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4/16/99 4 Donation 5 Other (Specify) Salisbury Crematory 21. Signature of Funeral Service License M01051 23a. Partí. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one causa on each me. **Physician** /Medical Immediate Ceuse (Final HYPERTENSIVE CARDIOVASCULAR DISEASE disease or condition Examiner Due to (or as a consequence of) bunal-transit and Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): attending physician for use es the buria Box 68760. The law requires that the death certificate be Physician/Medicai Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. the been signed by should be detact DIABETES MELLITUS Records, à Completed page 2 : hes certificate Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it Be 25. Was casa referred to medical 26. Place of Daath (Check only one) 2 1 Yes 2 No 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 Ĭ DOA 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 5 Panding investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be datermined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physicien: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) Medical 29a, Certifian (Check only one) end manner stated. 29b. Signature and title of certifier 29c. License number 6 Julpeley P.M.E. D0003599 30. Nama and address of person who complated cause of death (Itah 23a) (Typa, Print)

CARROLL

7. Age (In yrs. last birthday)

52 Yrs.

10c. City, Town or Location

2. Date of Death 3. Tima of Death Month CAIN 04 99 1916 4b. City, Town, or Location of Death 4c. County of Death SAL ISBURY If Under 24 Hrs. WICOMICO If Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min 09-09-46 West Virginia 10d. Inside City Limits 1 ☐ Yes 3 € No 10g. Citizan of What Country? USA Race - American Indian, Black, White, etc. Specify: WHITE 16b. Kind of Businass/Industry United Methodist Church 18. Mother's Name (First, Middla, Maidan Surname) Alfreda Mevers 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 20c. Location - City or Town, State Salisbury, MD 22. Name and Address of Facility Holloway Fuenral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Onset and Death

23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown

24b. Ware autopsy findings availabla prior to completion of cause of death? 24e. Wes an autopsy performed?

1 Yes 2 No 1 ☐ Yas 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

04-12-99

29d. Date signed (Month, Day, Year)

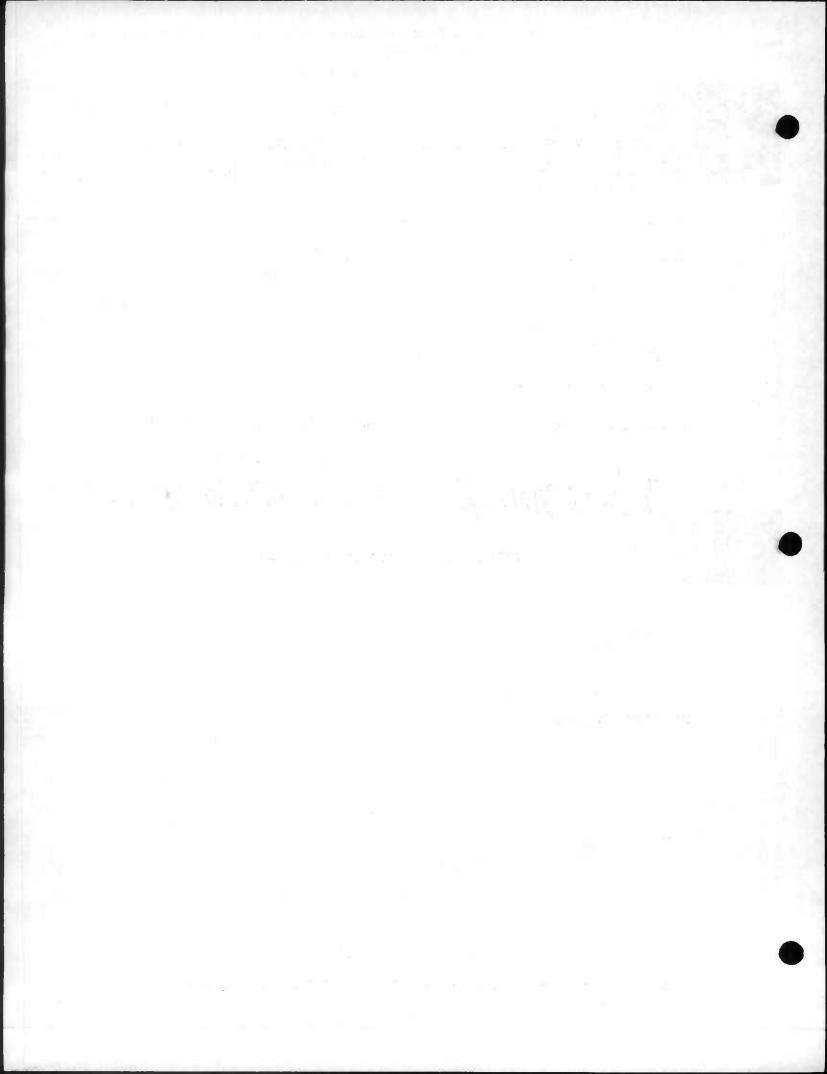
JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801

31. Date filed (Month, Day, Year)
APR 1 6 1999

32. Registrar's Signature

Sparky

State Registrar



		1. Decedent's Name (First, Mi	iddle Lest)		C	ertifica	ate of	Death	0.000	Reg. No.	T E		Time -1 5		
Physic	ian		oole, Last)	,						2. Date of	.5/99	Ye	ear 3.	Time of Death		
/Med Exam		Edna Conti 4a. Facility Name (If not institu	tion, give	street and nu	mber)				4b. City, Town, o			County of I	Deeth 5	55 P N		
LAGIII	n ici	Wicomico	=13.4						Calia		100					
Funera		5. Social Security Number	6. Sex	M 2DF	7. Age (In yrs		Month	der 1 Year Is Days	Salis I Under 24 H Hours Mi	rs. 8. Date of I	Birth Day, Year)	icom	Birthplece Country)	(State or Foreig		
Directo		218-16-8648 Usual Residence of Decedent		X 7	75	Yrs.					24/19:	24	Mary			
show		10a. State 10b. Cour	nty		10c. C	ity, Town or	Location				100					
the Maryla 28a-f shor	ctor	Md. Wico	mico		Sa	lisbu	ırv				1 Ye					
5 6	Director	10e. Street and Number			100		10f. 2	Zip Code	HA 344		10g. Citize	en ot What Country?				
23°		1012 Fairg						1801			U.S					
led within 72 hours efter death vigglene. Nor than "neturel", or items 23st. It. The Morrel Exercites must		11. Marital Status 1 ☐ Never Married 2 ☐ M		Armed Fo		U,S. 1	3. Wes Dec	pecify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or erto Rican, etc.)	No- 14		American In White, etc.	dien,		
		3 X Widowed 4 □ Divord		1 Tes If Yes, Giv Yeer or D	ates:	776	1 🗆 Yes	2 No	Specify:		S	Specify: W	hite			
		15. Deced (Specify only hig	dent's Edu	cation	5.00	18a. Dec	cedent's Us	sual Occup	petion	working	16b. Kind of Business/Industry			,		
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Be ever	11 17. Father's Name (First, Midd	fle, Last)	0		Nurs	sing	Ass	istant	ame (First, Midd			Care				
	Howard Dale	3.00	ns						Taylo		amamoy					
end M s mar	-	19a. Intormant's Name/Relation				19b. Ma	ailing Addre	ess (Street	and Number or			Town, Sta	ite, Zip Code	e)		
end z salth er n 27 is]	orraine Mic	iott	o, Dau	ghter	5108	Cor	per	Rd. Ed	den, Mo	d. 21	822				
Department of Health Important: If Item 27 any injury or other to once.		20a. Method of Disposition			20b.	Place of Dis	position (A	vame of		Date	20c. Loca		y or Town, S			
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1 Reducted 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parsons Cemetery 4/19 Salisbury														
Department Important: I eny injury o		21. Signature of Funeral Servi	Signature of Funeral Service Licenses MOO 417 MOO 417 MOO 417 MOO 417 MOO 417													
		Omelius	W	LAMUS	1											
		23a. Panti. Enter the disease.			ons that caused the death. Do not enter the mode of dying, such es cardiac or respi suse on each line.											
Physician /Medical		shock, or heart tailure. L	ist only or	cations that one couse on e	aused the dea	th. Do not e	enter the m	valvi ode of dyi	e, Md. ng, such es card	21814 iac or respiratory	arrest,		App tntei Ons	roximate val Between et and Death		
		Immediate Ceuse (Final	ist only or				enter the m	ode of dyi	ng, such es card	iac or respiratory		. L ,,	Ons	et and Death		
			ist only or		einem		Lus	ode of dyi	e, Md. ng, such es card with E	iac or respiratory		tere	Ons	et and Death		
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State Registrar

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DRIVE, SALISBURY, MD 21801

31. Date filed (Month, Day, Year)

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Service & Sports

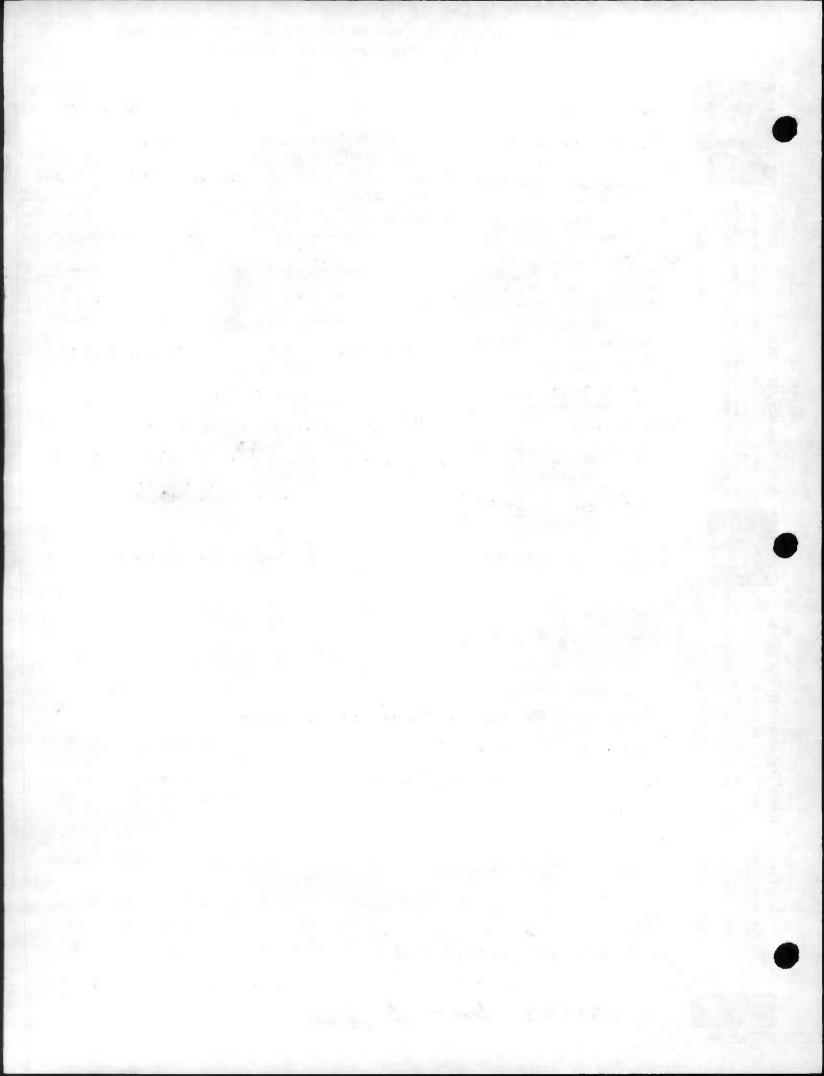
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State of Maryland / Department of Health and Mental Hygiene Gertificate of Death

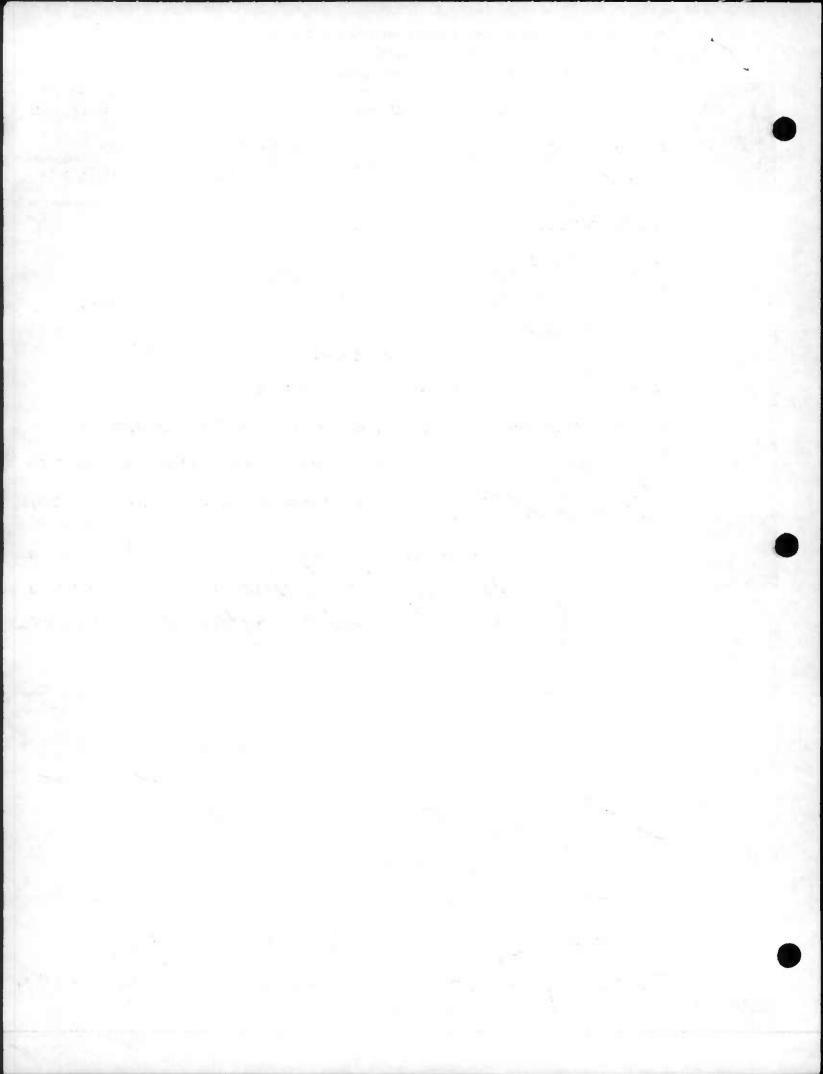
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Maryland	23a or 28a-f show at be notified at	10e. Stete MD	10b. County Wicor	mico	10c. City, T	own or Loc							10	ld. Inside City Limits 1 Yes 2 □ No
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Mal		19a. Informant's	Name/Heletions	hip (Type, Pnnt)		9b. Mailin	g Address (St	eet end No	imber or Hui	rel Route Numb	er, City o	r Iown, St	ate, ∠ip	Code)
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State of Maryland / Department of Health and Mental Hygiene

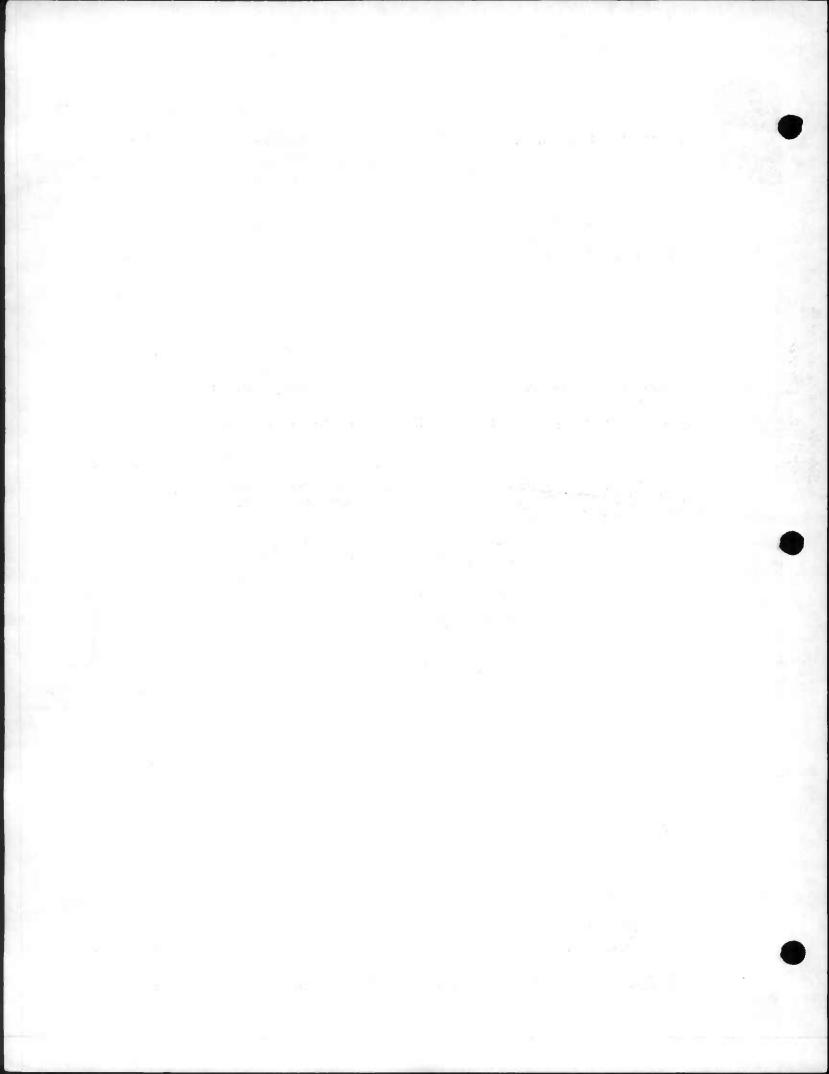
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or other treu		EDWARD S. CROPPEI				eiling Address (Street end Number or Rural Route Number, City or Town, St 11 JARVIS ROAD, BISHOPVILLE, MARYLA						
		20a. Method of Disposition	N/ DROTHER	20b. Place	of Disposition	Nema of			20c. Location			
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	/Medic		Sarah Cou						4h City Tayan and	APRI		999	1055
	Examin	er	4e. Fecility Neme (If not ins PENINSULA RI				ENTER		4b. City, Town, or L SALISB			I COMI	CO
	Funeral	ri.	5. Social Security Number	6. 5			yrs. lest birthda	y) If Under 1 Year		8. Date of Bi (Month, D	irth	9. Birth	plece (State or Foreig
	Director		093-26-5970 Usuel Residence of Decede		1□M 2 X F	89	Yrs.	Months Deys	Hours Min.	Sept 1	19,1909	Cou	MD
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020 urs efter dea	Desitimore, Maryland 21215-0020 Baltimore, Maryland 21215-0020 Desaturent of Health and Mentel Hygiene. Important: If team 27 is marked other than "natural", or items 23s or 28s-f show may injury or other traumetic event, it a Medical Expirition manuals on titled at once. To Be Completed by Funeral Director		11. Marital Status 1 Never Married 2 3 Widowed 4 Div		12. Was Dec Armed F 1 Yes If Yes, G Year or	2 ⊠ No ive	in U,S. 1:	3. Wes Decedent of If Yes, specify Cult 1 ☐ Yes 2 ☐ XIo	Hispanic Origin? (S) ben, Mexican, Puerto Specify:	pecify Yes or N o Rican, etc.)	Bie	ck, White,	
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B B	Day any any		15	/	1			Lewis N.	Watson F				
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Division of Vital Records,	ire deat irector: n by the	Certification:	3 Suicide 6 □ C	ould not be	e 28e. Plec	e of Injury - ling, etc. (S)	At homa, farm,	street, fectory, office			(Street end Numi	ber or Rur	el Route Number,
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e H	n 24 i	edical	29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 20 Medical Examiner: On the basis of exemination end/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.										o tha ceusa(s)
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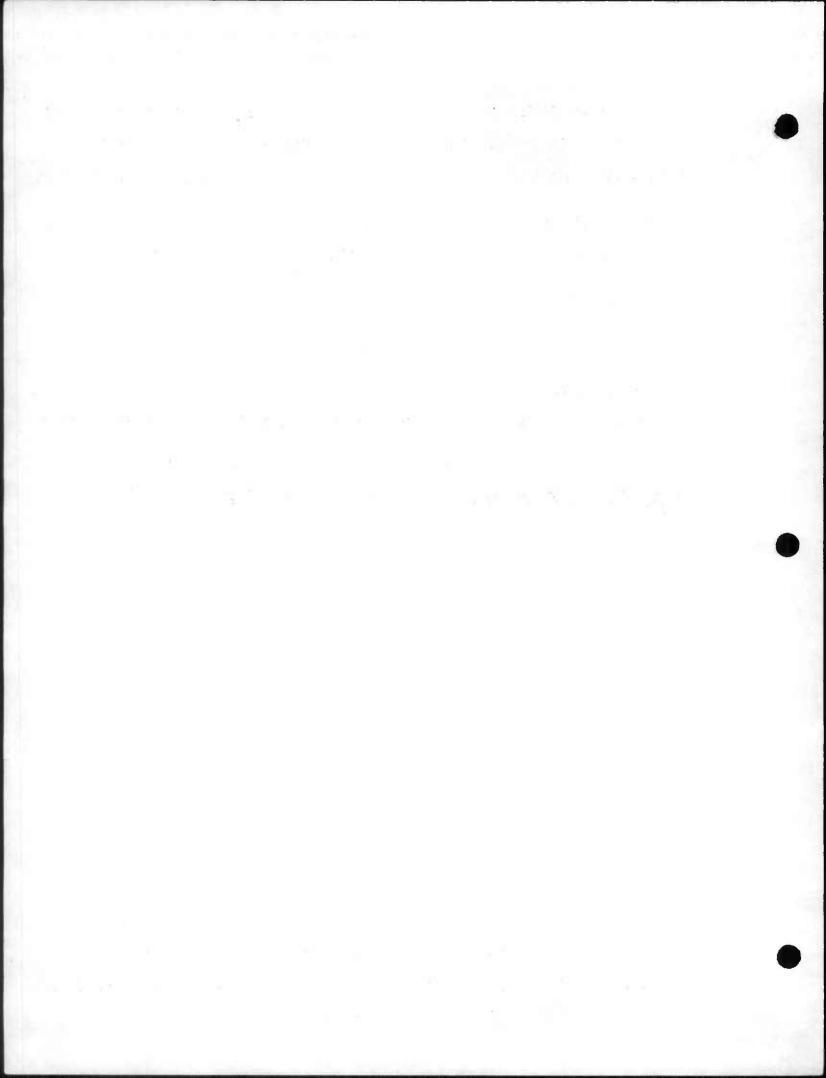
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Apri Max Augusta Chilcote /Medical 4a. Fecility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Undar 1 Year Months Devs If Undar 24 Hrs. Hours Min. 7. Aga (In yrs. lest birthday) Birthpieca (State or Foreign Country) **Funeral** 1₽M 2□F Deys Director 210-18-9155 72 June 29, 1926 Pennsylvania Usual Rasidenca of Decedent 10e State 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 Yas 2 No Director Franklin Zullinger 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 12222 Polktown Rd. 17272 U.S.A. Funeral "natural", or items 12. Wes Decedent Ever in U,S Armed Forces? 11. Marital Status Was Decedant of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Bieck, Whita, atc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☒ No it Yes, Giva 1 ☐ Nevar Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ Xio Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Haalth and Mental Hygiene Important: If Item 27 is marked other that any liqury or other traumatic event, the 2002s. Painter Homes 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Neme (First, Middla, Meiden Sumeme) Herman P. Chilcote 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Gode) Mabel B. Jacka 19e. intorment's Neme/Relationship (Type, Pnint) Laura A. Tracy (Friend) 20b. Plece of Disposition (Neme of cemetery, crametory or othar placa) 20a. Method of Disposition 20c. Location - City or Town, Stete Cremetion 3 Removal from State Smithsburg Crematory April 8, 1999 Smithsburg, Md. Donetion 6 ☐ Other (Specify 21. Signature of Funeral Sepulse Lic 22, Name end Address of Fecility 12525 Bradbury Ave. Davis Funeral Home an Smithsburg, Md. 21783 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one ceuse on each line. Approximete Intervel Between Onsat and Death **Physician** RESPIRATORY FAILURE immediete Ceuse (Final disaese or condition resulting in deeth) 2-3 Hows /Medical Examiner PULMONARY EMBOLISM SUSPECTED Physician/Medical Examiner 2-3 Hours the attending physician and hed for use as the bunal-transit that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immadiata ceuse. Enter Underlying Ceuse (Disease or Injury RENAL DISEASE YEM-S STAGE Box 68760. that initiated even Due to (or es a consequance of). resulting in death) Lesi 1-2 days NAM Division of Vital Records, P.O. Part II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ② No 3 ☐ Probably 4 ☐ Unknown Completed by 24a. Wes en eutopsy performed? 24b. Were eutopsy tindings available prior to completion of cause of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese reterred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 2 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA n 24 hours after death.

Funeral Director: After the pletaly filled in by the funeral 27. Menner of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: or Attending 1 Naturei 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homloide Hospital 1 Certifying Physictan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinerion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier (Check only one) within 2 29b. Signeture end title of certifier 29d. Dete signed (Month, Day, Year) D0053548 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Hagerstown Maryland Oak

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Biack indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** John Dawson Clark Apri 12 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington County Hospital Hagerstown Washington County 8. Dete of Birth (Month, Day, Year) Dec. 22, 1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdev) **Funeral** Days 1₩ M 2□ F Months Hours 73 215-20-5175 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Washington Co. 1 ☐ Yes 2 No Hagerstown Directo ã 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or items 23s or the Wedical Examiner must be 9721 Meadow Rock Drive 21740 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mortal Hyglene. Int: If flesh 27 is marked other than "natural", or like 1 Syes 2 2 No/27/43 If Yes, Give 2/27/43 Year or Dates: 5/12/46 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Truck Manufacturing n Inspector 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be Lacy Tasker John D. Clark, Sr. 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 9721 Meadow Rock Drive, Hagerstown, Maryland 21740 19a. Informant's Name/Relationship (Type, Print) Doris Anita Clark/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland Apr.16 Rest Haven Cemetery 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 23a Part T. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner requires that the death certificate be executed physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): attending ph for use as the lark, John Dauson 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No Ď 24b. Were autopsy findings eveilable prior to 24a. Was an eutopsy performed? Completed completion of cause of death? s cartificata has b 201 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case reterred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specity) 1 Yes 2 No patient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Deta of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a edicai Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completaly fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Medical

State Registrar NO

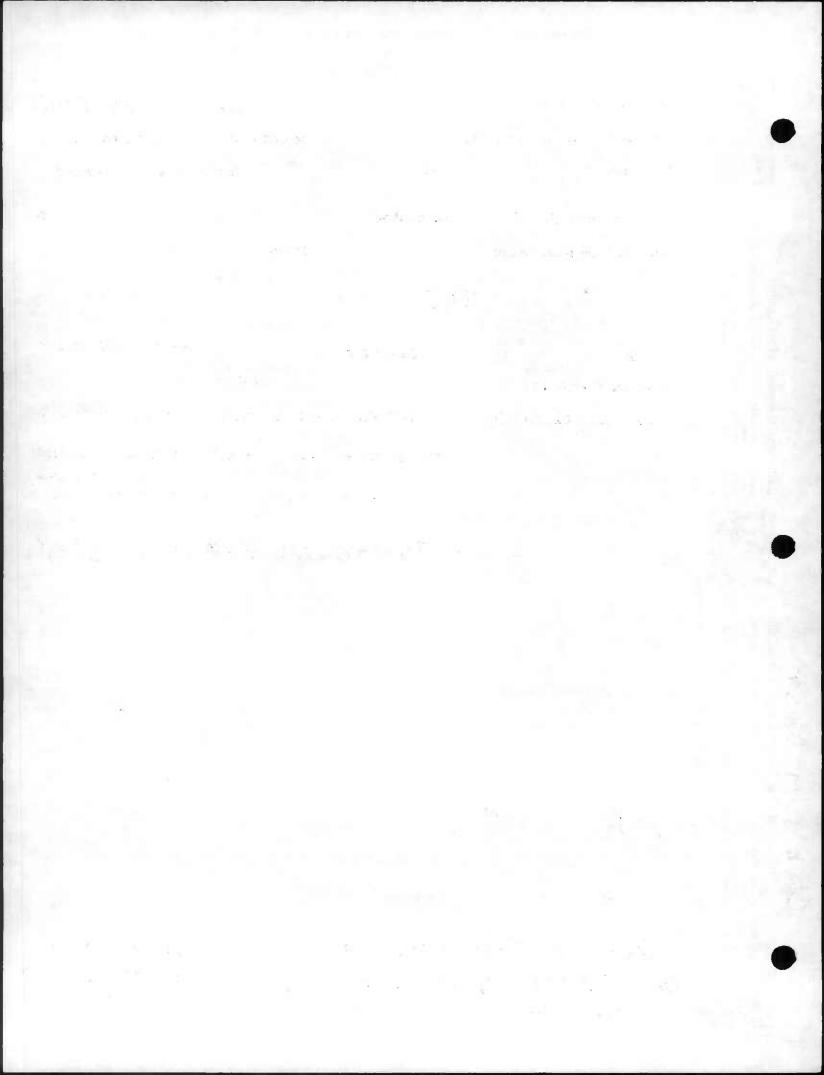
31. Date filed (Month, Day, Year)

APR

30. Name and address of person who completed duse of deeth (Item 23e) (Type, Print)

3

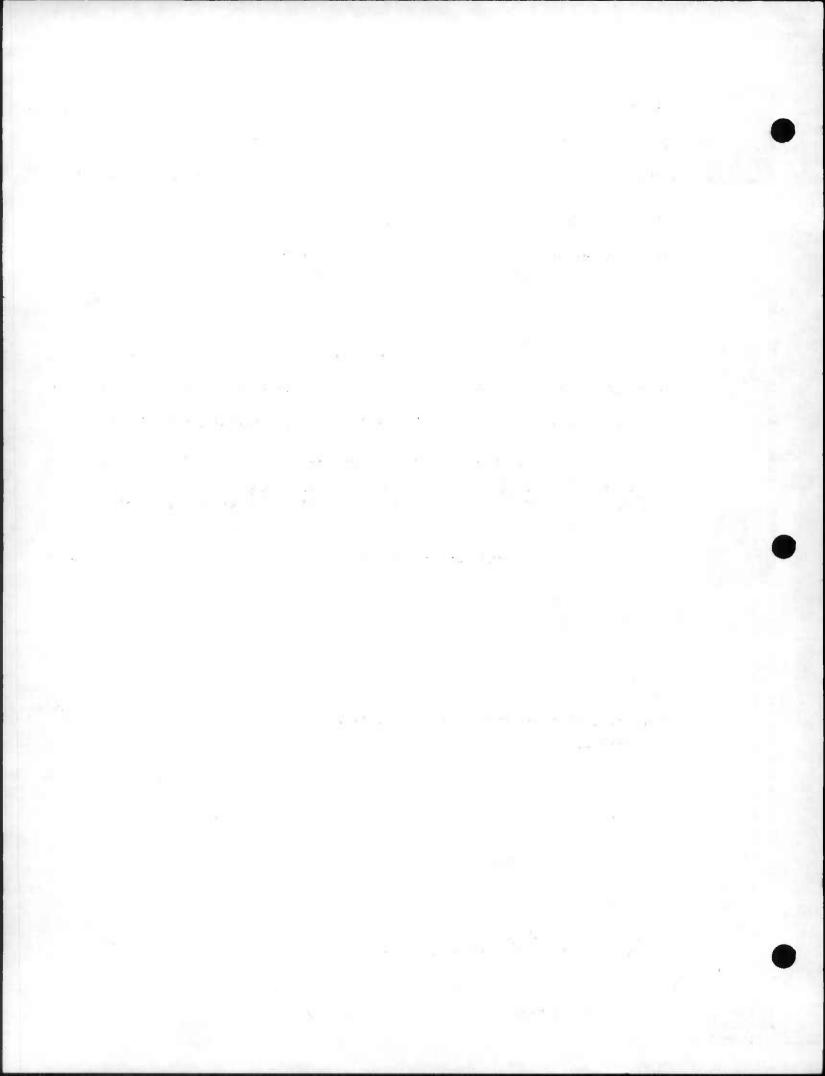
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 9

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Physician /Medical Examiner	
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Baltimore, Maryland 21215-0020 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 3 State Registrar

Residence of Decedent late 10b. County ID Garre Treet and Number O Oak St., Apt rital Status Naver Married 2 Married Widowed 4 Divorced 15. Decedent's Edu (Specify only highast gradentary/Secondary (0-12) 10th her's Name (First, Middle, Last) Seph Edward Greg Informant's Name/Relationship (T) Tree Lockie/ Daug	onham streat and number) Y Memoria A 7. Age (In 5) 10cett 11. Was Decedent Ever Armed Forces? 1 Year or Dates: Idection College (1-4or 5+)	yrs. /ast birthdo	Location ke Par 10f. Zip 3. Was Decet If Yes, spect	R Days k Code 2155 dent of Heiry Cubs	Oakl If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, 10/20/4)	Day 14, 1 4c. County Garr Year) Og. Citizen of V	9. Birthp Coun Mary]	0d. fnside City Limits 11√1 Yes 2 □ No try? Aen Indian,			
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21. Signature Funeral Service Licensee 22. Name end Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, MD 21550												
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31. Date filed (Month, Day, Year)

32. Registrar's Signature

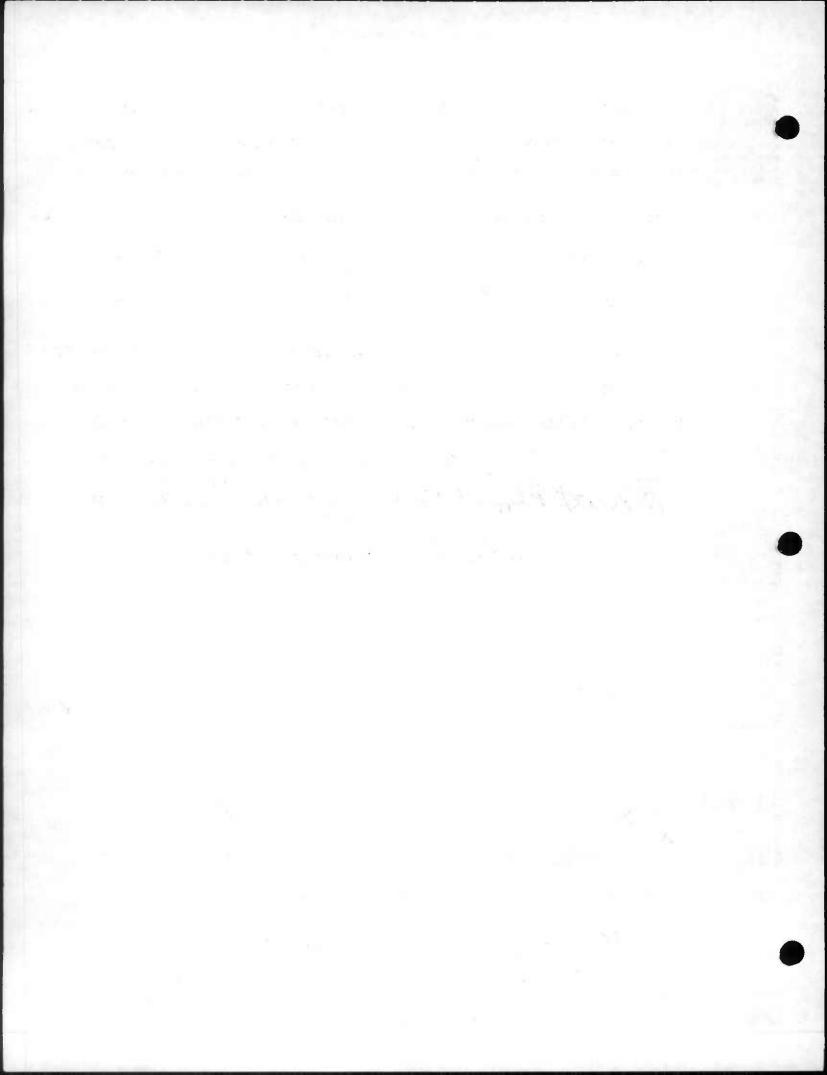
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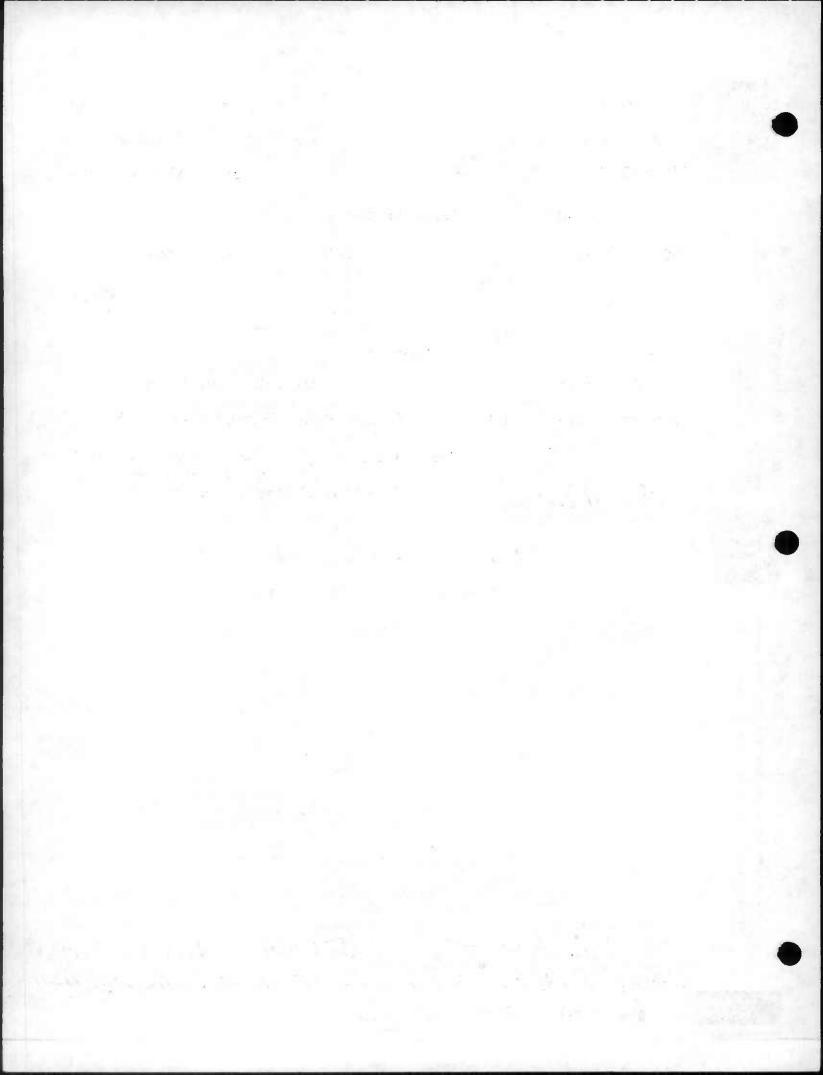
State of Maryland / Department of Health and Mental Hygiene 9 9 4 3 2 0

								Cer	tificate	of	Death		R	ag. No.			
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)	Exami		4a. Facility Nama (If not institu	tion, giva	straat and nu	ımbar)					4b. City, To	wn, or L	ocation of Daath	4c. Cou	nty of Daath		
			26780 PEMBE	-								LISI	BURY		WICOM		
	Funeral		5. Social Sacurity Number	6. Sa	x ∃M 2]X∂F		(In yrs. last birt	hday) (rs.	If Undar 1 Months	Yaar Days		24 Hrs. Min.	8. Data of Birth (Month, Day OCT . 15,	Year)	9. Birth	placa (Stantry)	ata or Foraign
V.	Director		217-28-2919 Usual Rasidance of Decadant			6	7	15.					OCT.15,	1931	MARY	LAND	
	land		10a. Stata 10b. Cou	nty			10c. City, Towr	or Loc	ation		-				10d. Inside City Limi		
	Mary -f sh	Ö	MD	W	ICOMIC	0				SA	LISBUR	RΥ				1 🗆	Yes 2 No
	the note	Director	10e. Street and Number						10f. Zip C	oda			1	of What Cou	ntrv?		
	3a o	Funeral D	7523 TITL					2180)1		U.	S.A.					
	and 21215-0020 be filed within 72 hours after death with the Maryland rital Hygiene. od other than "natural", or items 23a or 28a-1 show event, the Medical Examiner must be notified at event.		11. Marital Status		12. Was Dac		var in U,S.	13. W	/as Daceda	nt of I			ecify Yas or No- Ricen, etc.)	14. F	ace - Amari		n,
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Maryland	It More, It. Peges 1 ar It. Peges 1 ar It. Ment of Heal Itant: If Item 2			ant's Name/Ralationship (Type, Print) CCIA L. HATTON - DAUGHTER							ERTON		al Route Number SALISB				
re,			20a. Mathod of Disposition	AIIO	N DA	OGIII	20b. Place of	Dispos	ition (Nama	of		DIC.		20c. Locatio			a
9			1 X Burial 2 ☐ Cramatic 4 ☐ Donation 5 ☐ Other			Stata			atory or oth			ENS	4-21-99	HERI	RON. M	m	
E E			21. Signature of Funaral Sarvi				DIRING	1			ass of Facilit			. MAI			
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m .	death e atte	sicia	Part II. Other algnificant cond	tions cor	ntributing to d	eath but	not rasulting in	tha un	dartving cau	sa di	van in Part I		23b. Did to	hacco uas	contribute t	n the car	ise of death?
P.0	The law requires that the death of the law seem signed by the attendage 2 should be deteched for u	Physician					3		, , , , , , , , , , , , , , , , , , , ,					es 2 No			4 Unknown
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E		Con											1 🗆 Ye	es 20 No	1	□Yas	2□ No
Vit	Attending Physician: The is releath. ector: After this certificate he by the funeral director, page	Be	25. Was cesa rafarred to medi axaminar?		loonital.					011		of Daat	h (Check only on	a)			
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on	ding Phys h. After this funeral d	tion	1 Natural 5 □ Pen	ding stigation	(Mon	th, Day	Year) 28b. T	jury	M 200	. Inju Wo	nk?]Yas 2∐		28d. Dascribe ho	ow injury occ	urrea		
18	or Attendi efter death Director: A I in by the f	fica	3 ☐ Suicida 6 ☐ Cou	d not be	28a, Place	of Injun	y - At homa, far	m stra			7103 201		28f. Location (St	reet and Nu	mber or Rur	al Routa	Vumber
2	s effer I Dire	Certification:	4 Homicide	mined	buildi	ing, etc.	(Specify)	in, atra	at, ractory, c	11100			City or Town		77007 07 7101	s, , , obta ,	voinbor,
	To the Hospital or Attending Ph within 24 hours elder death. To the Funeral Director. After thi completely filled in by the funeral	edical (29a. Cartifiar (Check only one) Certify	ing Phys	nician: To tha ner: On tha band man	asis of a	xamination and	daath /or Inva	occurred at astigation, In	tha ti	ma, data and opinion, daai	d place, th occurr	and due to the co rad at tha time, d	eusa(s) and ata and plac	menner as s e, and dua t	stated. o tha ceu	se(s)
	Withir To th	Me	29b. Signatura and	lior					29c. l	ican	sa numbar		2	9d. Date sig	ned (Month,	Day, Ye	ar)
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	9		Dosent it	, ()	KM 33		145	B.	CAM	er	ous	24	Sous	SBYR	N	(YY)	
Ì	Sta		31. Data filed (Month, Day, Yas	-		lagistrar	s Signatura		-						7		
	Registr	ar	APR 1	9 19	99	Der	wa	5	S.	0	Kal.						
DHN	1H 16 Rev 6/9	5			/		/		1	-							



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					Cel	rtificat	e or	Death		Reg.	No.				
Physic		1. Decedent's Name (First, Middle, Last ELIZABETH C	AROL DU	LL					2. Date Mor Apri	e of Deeth	Dey	Yeer IQ	3. Time of Deeth 0620		
/Medi Examir		4e. Fecility Neme (If not institution, given Lorien Nursing						4b. City, Tow Balti	n, or Location o	of Deeth	4c. County Balti	of Deeth	0020		
Funeral Director		5. Social Security Number 6. S 218-54-3601 Usual Residence of Decedent	DM OME	(In yrs. lest 48	birthday) Yrs.	If Under Months	1 Year Deys	If Under 2 Hours	Min. (Mo	of Birth onth, Day, Ye	1950	9. Birthpla Country Wayne	ce (State or Foreig Sboro, P		
a-f show	ctor	10e. State 10b. County 10c. City, Town or Location										100	I. Inside City Limits 1X Yes 2 □ No		
h with the	Funeral Director	10e. Street end Number 85 Fairground RD		10f. Zip Code 20698					10g. Citizen of Whet Country? USA						
permit. Peges 1 end 2 should be filed within 72 hours effer deeth with the Maryland Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat result be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		'	Was Decedif Yes, specific	cify Cube	lispenic Origi en, Mexican, Specify:	in? (Specify Ye: Puerto Rican, e	s or No- itc.)		ca - American ck, White, etc.	c.		
	Completed	15. Decadent's Ed (Specify only highest gre Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+		6e. Deced (Give life. L	ecedent's Usuel Occupetion Give kind of work done during most of wo ife. DO NOT use retired)			of working	orking 16b. K		Kind of Business/Industry			
	Be	12 17. Father's Neme (First, Middle, Last) Donald D. Dull			aker			's Name (First, Elizat		iden Surneme)					
	10	19e. Informent's Name/Relationship (1 Barbara E. Ward	Type, Print) Sister			ng Address		end Number	or Aurel Aoute Prince	Number, Ci	ity or Town,		Code) 20698		
		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremetion 3 ☒ 4 ☐ Donetion 5 ☐ Other (Specify			itery, cren	sition (Ner matory or o	ther plea		~						
Deperting any inj		21. Signeture of Funeral Servica Lican	see					ss of Fecility	Grove Waynesb			ome, I 7268	nc.		
physicials the burners of the burner	/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest	· Por	Jue to (or as Jue to (or as Jue to (or as	a conseq	uence of):	Ae.	aut	Faile	v.					
es been signed by the ettendi	lan	Pert ti. Other significent conditions co	g In the ur	nderlying c	ause giv	en in Pert I.	23	29b. Did tobacco use contribute to the cause of de							
igned by the e be deteched f	by Phy			1					2□ N o	3 Probai	bly 4 Unknow				
hes been si ge 2 should l	Completed								246	performed?			eutopsy findings bie prior to pletion of cause eth?		
pe	Be Cor	25. Wes case referred to medical						26 Place	of Deeth (Check	1 Yes	2 🗆 No	101	res 2□ No		
Is certific director,	ToE	exeminer?	Hospitel: 1 Inpatient	t 2 ER/0	Outpatien	t 3 DC	Oth	or.	sing Home 5		6 □Oth	er (Specify)			
actor: After this certific by the funeral director.		27. Menner of Deeth 12 Naturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Year) 28b	o. Time of Injury						njury occur	red			
Diractor:	THE P	4 Homicide determined	building, etc.	(Specify)					City	or Town, S	tete)		Route Number,		
ours efter eral Dirac filled in by												to the ceuse(s) end menner es steted.			
in 24 hours efter he Funerai Dirac pletely filled in by	edicai		iner: On the basis of e	examinetion e	(Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and end menner stated. 29b. Signature and title of capitier 29c. License number 29d. Date signed (M										
within 24 hours effer deeth. To the Funeral Director: After completely filled in by the fune	edicai	(Check only 2 Medical Exami	iner: On the basis of e	examinetion e	end/or inv	restigetion,	in my o		occurred et the	time, dete	end placa,		e cause(s)		
within 24 hours effer To the Funeral Dirac completely filled in by	Medicai	(Check only 2 Medical Example) 29b. Signature and title of Castifier	iner: On the basis of e	examinetion e	end/or Inv	estigetion,	in my op	e number	occurred et the	time, dete	Date signe	d (Month, De	e cause(s)		



Physician				Certificate	Of I	Death		Reg. No.				
	Decedent's Name (First, Middle, La	est)				2. Date of Dec Month	Day	Year	3. Time of Death			
/Medical	WARREN FRAN	CIS EBERL		APRIL		19 1999 2.						
Examiner	4a Facility Name (If not institution, giv	re street and number)			4	4b. City, Town, or l	ocation of Death					
7.2	22715 LAWRENCE AV					LEONARI			MAR			
Funeral	5. Social Security Number 6. S	Sex 7. Age	7. Age (In yrs. last birthday) If Under Months			If Under 24 Hrs. Hours Min.	(Month. Day	h y, Year)	9. Birthp	olece (State or Foreig ntry)		
Director	Usuel Residence of Decedent	X	68	115.			10V. 26	,1930	MAR	YLAND		
ž.,.	10a. State 10b. County	1	10c. City, Town	n or Location					1	10d. Inside City Limits		
28a-f show	MARYLAND ST.	MARY'S		T.EOI	NAR	RDTOWN			NE Yes 2□N			
ect Est	10e. Street and Number	HISKI O		10f. Zip (DIOWN		10g. Citizen of 1	ntry?			
2 should be filed within 72 hours after death with 1 and Mental Hygiens "netural", or items 23a or is marked other than "netural", or items 23a or raumstic event, the Medical Example must be To Be Completed by Funeral Di	22715 LAWRENCE	AVEnue	550			.S.A.						
	11. Marital Status	12. Wes Decedent Ev	ver in U.S.				pecify Yes or No-			can Indien,		
	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No		tf Yes, specif	y Cuba	lispenic Origin? (S an, Mexican, Puert	o Ricen, etc.)	Bla	ck, White,			
	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give A Year or Detes: W	DMV	1 ☐ Yes 2	No	Specify:		Specif	WH:	ITE		
	15. Decedent's E	ducation		Decedent's Usual	Occup	pation		16b. Kind of Business/Industry		dustry		
	(Specify only highest green Elementery/Secondary (0-12)	College (1-4or 5+)	Decedent's Usual (Give kind of work life. DO NOT use	retired	during most of wor d)	King					
	9	00.000		WATERM	AN			SELF EMPI		PLOYED		
	17. Father's Neme (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Suman	ne)			
	JOSEPH FRANK	EBERLE				MARY	KATHL	EEN AI	DAMS			
	19a. informant's Name/Relationship (er, City or Town,	City or Town, State, Zip Code)									
	MARGARET EBER	LE - SPOU		SAME AS		.0						
	20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or cemetery, crematory or other place)											
Department of Important: If It any Injury or once.	Surial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) EVERGREEN MEM.GARDENS 4-22-99 GREAT MIL											
Important: any injury once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A.											
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sician	snock, or neart rellure. List only	~			-	-, .	or respiratory at			Approximate Interval Between Onset and Death		
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State Registrar 30. Name and address of berson who completed cause of dec DR. JAMES JARBOE PHILIP

Registrar's Signature

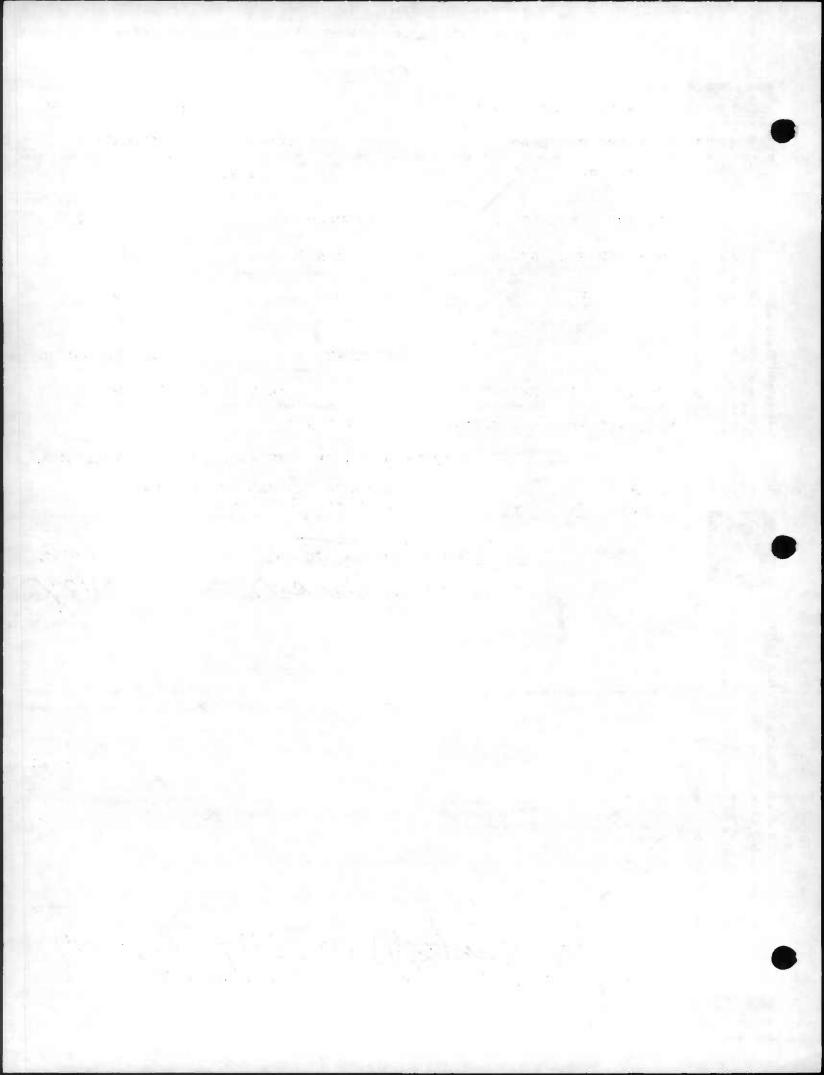
31. Date filed (Month, Day, Year)

DHMH 16 Rav 6/95

NAME: WARREN EBERLE

porks

BEAN MEDICAL CENTER, HOLLYWOOD, MD @20636

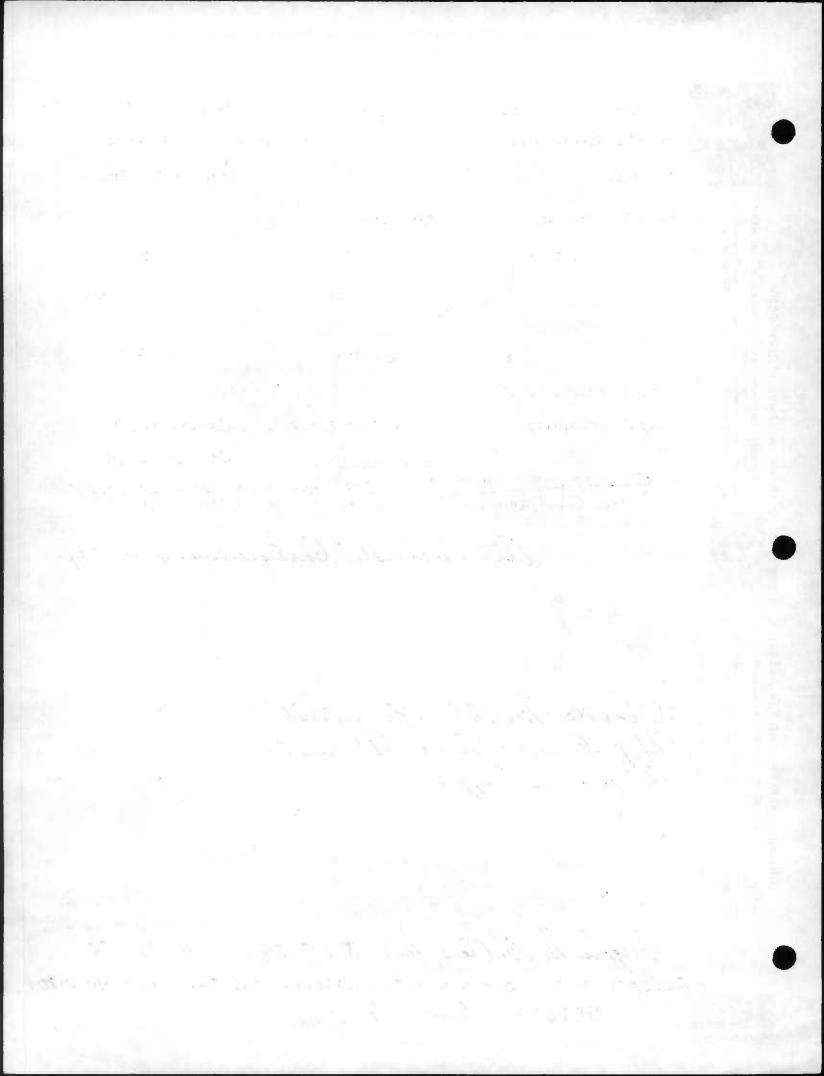


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** 1999 10:50pm April 10 WILBER RUSSELL ELLIS /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Name (If not institution, give street and number) Examiner Wicomico Nursing Home Salisbury Wicomico If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth Months Devs Hours Min. (Month, Dev, Yeer) 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1MM 2□ F Deys Yrs. Director 215-44-5945 August 9,1921 Virginia Usuel Residence of Decedan 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryla traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Salisbury Director Maryland Wicomico 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5 238 617 Twin Tree Rd. 21801 USA Funeral 14. Race - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 11. Marital Stetus Black, White, etc. 1 ☐ Never Married 2 ☑ Married 6 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16e. Dacedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eigmentary/Secondary (0-12) Collage (1-4or 5+) Medicine 12 6 Physician other 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Be Pagas 1 and 2 should be filment of Health and Mental Hant: If Item 27 is marked out Wilber Russell Ellis Miriam Pond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straet end Number or Rural Route Number, City or Town, State, Zip Coda) Mary C. Ellis/Wife 617 Twin Tree Rd, ., Salisbury, MD 21801 other t Baltimore. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from State injury or Department important: If 4/14/99 Salisbury, MD 4 ☐ Donetion 5 ☐ Other (Specify) Wicomico Memorial Park 22. Name and Address of Fecility 21. Signation (Funerel Service Licensee M01051 Holloway Funeral Home Professional Association Perf. Enter the disease, or complications and caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

A Approximete Intervel Between Onset and Deeth **Physician** olie Carlionsoular Desau /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Examiner Sequentielly list conditions, if eny, leading to immediate ceusa. Enter Underlying Cause (Disaasa or injury that initielad events resulting in death) Last ţ Dua to (or es e consaguance of): pug physician Box 68760 Physician/Medical å Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the causa of death? ğ ď 1 Yee 2 No 3 Probably 4 Unknown signed be det Division of Vital Records. p 24b. Were eutopsy findings evellable prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy peed 1 ☐ Yes 2 No 1 Yes 2 No certificate Theene 25. Was case elerred to medicel axaminar? Be 26. Pleca of Death (Chack only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 뫮 28e. Deta of Injury (Month, Dey Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? Attending 1 Naturel 2 Accident 5 Pending 1 Yes 2 No To the Hospital or Attendi within 24 hours after death To the Funeral Director: A invastigation 6 Could not be 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 D Hamicide 1 Certifying Physician: To the bast of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end mennar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, data and place, and due to the causa(s) end menner steted. Medical 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P 29505 12.11 M. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DR., SALISBURY, MD 21801 31. Date filed (Month, Day, Yeer) 32. Registrer Signature State APR 13 1909 Registrar



State of Maryland / Department of Health and Mental Hygiene Cartificate of Dooth

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Diversity		1. Decedent's Name (First, Middle, Last)										2. Date of De Month	ath Day	Year	3. Time of [Deeth	
Physic /Med		Marian E				Arril	- 15,1	999	500	Pr							
Exami		4a Facility Name (If	not institution,	give street and nut	m <i>ber)</i>					4b. City, To	wn, or L	ocation of Deet	h 4c. County of Death				
		13108 Bl		Hagersto		wn	Washi	ngto	n Count	unty							
Funeral		5. Social Security No		6. Sex	7. Age	(In yrs. last bi		If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th v. Year)	9. Birt	hplace (Stete or untry)	Foreign	
Director		319-22-5	491	1□M 2⊠F	XF 70 Yrs. Months				Duys	110010	1001111	May 7,		Ill	inois		
P		Usual Residence of Decedent											1.4.4.1.10.40.10.40				
how		Maryland Washington Co. Hagerstown													10d. Inside City		
8 Me	filed within 72 hours after death with the Maryland thygiene. ther than "natural", or items 23a or 28a-f ahow out, the Medical Examinet must be notified at a Completed by Funeral Director	Maryland	wasnii	igton to.		Hager	rsto	WII					1 🗆 Yes				
or 2		10e. Street and Num						10f. Zip					10g. Citizen of		untry?		
th w	a	13108 Bl	ue Rido	ge Road				21	742				USA				
dea	nec	11. Marital Status	12. Was Deci	edent E	ver in U,S.	13. \	Was Deced	ent of F	lispanic Ori	gin? (Sp	ecify Yes or No Ricen, etc.))- 14. Ra	ce - Ame	ricen Indian,			
afte or the	F	1 Never Marrie	ed 2 Marrie		2 X N								Specify: White				
ours ours	l by	3 Widowed	4 ☐ Divorced	Year or D	ates:										open,		
be filed within 72 hours aff tel Hygiene. Id other than "netural", or event, the Weddesl Exem-	Completed		15. Decedent's	s Education t grade completed)		16a	. Deced	dent's Usua kind of wor	l Occup	etion during mos	of work	ing	16b. Kind of	f Business/Industry			
Z1Z15-00Z0 d within 72 hours af giene. r than "natural", or the Medical Exam	npi	Elementary/Secon	College (1-4or 5		(Give kind of work done during life. DO NOT use retired)				1)							
aryiding ZIZ should be filed within nd Mental Hygiene. marked other than imatic event, the M	To Be Cor	12		4		Ho	Homemaker				18. Mother's Name (First, Middle			Own Home			
De file of the other of the other of the other o		17. Fether's Name (in Thomas J							e (First, Middle ve Cost		me)						
Eshould be and Mental is marked o		IIIOlias U	. Egail							Gen	evre	ve Cost	erro				
re, Maryland s 1 and 2 should be file f Health and Mental Hy tem 27 is marked othe other traumatic event		19a. Informant's Na						-					er, City or Tow				
e, N 1 and Health 9m 27 ther tr		Raymond	A. Egai	n/Husband	l					dge R	oad,	Hagerst	own, Mai	:yLar	nd 21742		
of He		20a. Method of Disposition 20b. Placa of Disposition (Name of cempetory or other place) 1 Removal from State 20c. Placa of Disposition (Name of cempetory or other place) Rest Haven Cemeters										Apr. 20	20c. Location			-	
CAMILIMORE, Semit. Pages 1 a Separtment of Heamportant: If tem iny injury or otherace.		4 Donation	Rest	Rest Haven Cemetery						Hagers	town	, Maryla	and				
permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to Dage.		21. Signature of Fur	neral Service	4/ 7			22	. Name an	d Addre	ss of Facilit	У		**				
Depa impo		1/11	411	- Jumm	Win	nan.						uneral		Man	13 2	1710	
		23a. Part1. Inter the shock, or hear	e dis ase, or o				not ent	er the mode	e of dyi	ng, such as	cardiac	or respiratory a	erscowr.	, Mar	yland 2 Approximate		
Physician		shock, or hear	t la ure. List o	only one cause on e	each lin	10.									Interval Betw Onset and D		
/Medical	н	Immediate Cause (f	Final					1	0	sucr	0 0	0		- 3		^ .	
Examiner		disease or condition resulting in death)	1	e	~	mon	rei		1	200	ea,	7			mont	(h)	
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per man	Examine			b		Duo to /or on o	000000	wones of):								-	
be execute ician and burtal-trans	Exa	if any, leading to im-	mediate	100	'	Due to (or as a	CONSEC	querice or).									
certificate be e drug physician use as the buria	n/Medical	resulting in death) L	ast		ı	Due to (or as e	conseq	uence or):									
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Q # # 0	ciar													. 10 1 4			
5 6 62	Physicia	Pert II. Other signific	cant condition	s contributing to de	eeth bu	it not resulting	in the u	nderlying ca	ause gi	ven in Part I				_	to the cause of		
That if												10	Yes 2 No	3∐ P	robably 4 L	Jnknow	
Sign and b	d by											24a Was	an eutopsy	24b.	Were autopsy tir	ndinas	
pean s should	ete											perf	ormed?		available prior to completion of ca)	
0 # # W	Completed													1	of death?		
The : The :												1 🗆	Yes 2 No		1 ☐ Yes 2 ☐ I	No	
ician: The	Be	25. Was cese referre	ed to medicel	Hear hab					10		of Dea	th (Check only	one				
# 0 H	0		No	Hospital:										ome 5 Residence 6 Other (Specify)			

Division of

To the Hospital

Within 2

Certification: Medical

4 Homlcide (Check only

27. Manner of Death

1 Natural

2 Accident

3 Suicide

6 Could not be determined

28e. Date of Injury (Month, Dey Year)

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how Injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29b. Signature end title of certifier

28c. Injury at Work?

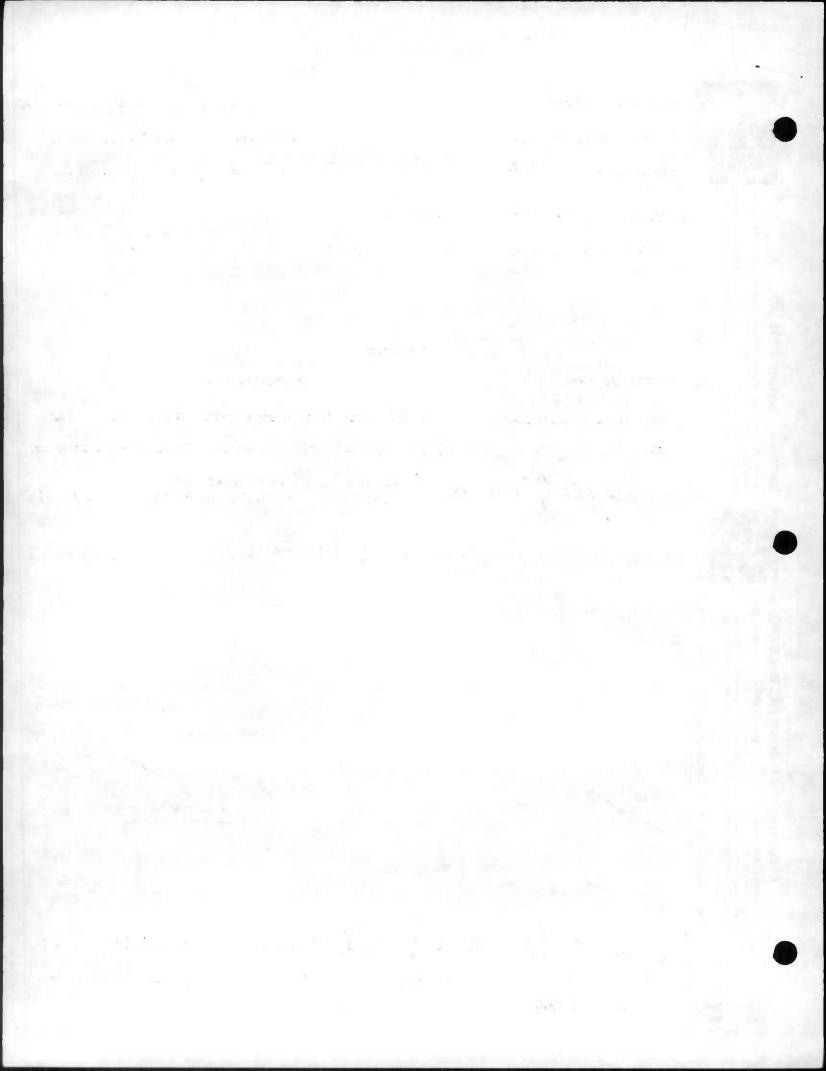
who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Dey, Year) APR 1 9 1999

5 Pending investigation

32. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				C	ertificate of	Death		R	eg. No.		
		1. Decedent's Neme (First, Middle	, Last)	77/2-0		TE		2. Dele of Dea	th		3. Tima of Death
	Physician	WILLIAM	(NMN)	GOETZ,	IR			April	15 I	999	2315
	/Medical	4a Fecility Neme (If not institution			, ,	4h City To	wn or L	ocation of Deeth	4c. County		2313
ji .	Examiner	Control of the Contro									
		l37 Channel			Williador 4 Voca		an C			este	
F	Funeral	5. Social Security Number	6. Sax 7 1 M M 2 ☐ F	7. Age (In yrs. lest birtho	Months Devs		24 Hrs. Min.	(Month, Dey	Yeer)	9. Birthp	plece (Stete or Foreign
C	Director	107-07-8530	TOM 201	81 Yr				Aug.5	, 1917	New	York
P		Usuel Residence of Decedent									
Yar	P P	10a. Stata 10b. County		10c. City, Town o	r Location					1	10d. Inside City Limits
Σ		Md. Work	cester	Ocea	n City						1 X Yes 2 □ No
the	728 Tec	10e. Street end Number	200101	0000	10f. Zip Code			1	0g. Citizen of V	Whet Cour	ntry?
5-0020 72 hours after death with the Maryland	where 23s or 28s-f show that must be notified at Funeral Director	137 Channel Bu	ov Pd		218	1112			US		
eath	era	11. Marital Status		dant Ever in U,S.	13. Wes Decedent of		igin? (Sn	ecify Yes or No-		e - Amaric	can Indian,
, d	The Part of the Pa		Armed Ford	ces?	If Yes, specify Cul	ban, Mexicar	n, Puerto	Rican, etc.)		ck, White,	
2 ag	0.50	1 Navar Marriad 2 Marri	ed 1XX Yas 2	etes: WWII	1 ☐ Yas 2 🙀 No	Specify:			Specify	wh	nite
000	"naturel", o	3 Widowed 4 Divorced	Yeer or Dat	tes:							
72 1	ete last	15. Decedent (Specify only highes		16e. De	ecedent's Usual Occu Rive kind of work done Te. DO NOT use retin	ipetion e durina mos	t of work	ing	16b. Kind of Bi	usiness/In	dustry
within		Elementery/Secondary (0-12)	College (1-	4or 5+)	e. DO NOT use retin	ed)					
D'	omp	12		Te	eletype In	staller	^		Phone	Com	ipany
Tiled S	1 2 2 4	17. Fathar's Nema (First, Middla, I	.ast)			18. Mothe	er's Nem	e (First, Middle,	Maiden Sumen	ne)	
D 20	merked o	William Henry	Goetz			Lill	ian	Leas			
should		19a, Informant's Nama/Relationsh		19b. N	lelling Address (Stree				r. City or Town.	State. Zic	Code)
	7 is m traum	Ronald William			0 Superfin						
	tam 27 other tr				isposition (Neme of		,		20c. Location -		
Saltimore,	0 = =	20e. Method of Disposition 1 ☐ Burial 2 ☐ Cramation	3 ☐Removal from S	cem etery,	cremetory or other pie						
Pages	2 44 2	4 □ Donation 5 □ Other (Sp		Cape H	enlopen C	remate	ory	4-16-99	Frankf	ord,[Delaware
Baltir parmit. P	Important: I any injury o	21. Signature of Juneral Service I	loensee		22. Nama and Addr	ass of Facili	ty				
n a	any Ir	& W Sie	134.6	0.	The Burk	page F	une	ral Hom	e		
		- Ili / NOW	Sum	used the death. Do not ch line.	108 William	St.,	Bei	rlin, Md	. 21811	-	-
		23a. Pay11. Efter the disease, of shock, or heart fallure. List	only one cause on an	lused the death. Do not ich line.	enter the mode of dy	ing, such as	cardiac	or respiretory err	est,		Approximate Intervel Between
Phy	ysician					^	1	1	1		Onset end Death
24	Nedical	Immediate Cause (Final disease or condition		0	· anaun	1	rte	uz U	si sea	90	
Ex	aminer	resulting in deeth)	Θ	Due to (or es e cor	reacuence of):			-()			
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6876U,		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury	G			_	_			i	
X 58/50 antificate to	A P	that initiated events resulting in deeth) Lest		Due to (or es e con	sequence of):					i	
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	ed by the attend detached for us y Physician/	Part II. Other significant conditio	ns contributing to der	ath but not resulting in the	a undariving cause g	ivan in Pert	i.	23b. Did to	obacco use co	ntribute to	o the cause of death
2 5	ed sk	, arriversignment contains	to continuous g to coo	attroot not reconting in th	ia onoanjing oadoo g	Train in total			L -	3 □ Pro	
T is	deb y							1 U Y	as Sab Mo	3 FIO	bably 4 Unknow
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Spio	page 2 should							24e. Was a perfor		ev	veilable prior to
N 0	2 st									of	ompletion of ceuse death?
The law	page 2							1□Y	es 2 No	1[☐ Yes 2☐ No
2 2		25. Wes cese referred to medical				oc Dis-	(D)				
OT VITA	inector o Be	examiner?	Hospitel:		0	thor		th (Check only or			
D Str	20 -	1 Yes 2 No	1 L In	patient 2 ER/Outp	STIENT 3LI DOA	4 L N	ursing Ho	ome 5-Resid			(y)
	and o	27. Manner of Deeth 1 Naturel 5 □ Pending	28e. Dete of (Month	f Injury 28b. Tim n, <i>Day Year)</i> Inju	ry W			28d. Describe h	ow injury occur	red	
VISION	T Line	Accident investig	ation		M 1	∃Yes 2□	No				
5 4	Director: 3 in by the ertifical	3 Suicide 6 Could n	ned 289. Fiece o	of Injury - At home, ferm g, etc. (Specify)	, street, fectory, office	•		28f. Location (S City or Tow	treet end Numb	ber or Run	el Routa Number,
5 3	at Director: After and in by the tuner.		Donon	g, etc. (Opecny)				y	.,,		
Hospital		29a, Certifier 12 Certifying	Physician: To the b	pest of my knowledge, d	eath occurred et the I	time, dete er	nd plece.	end due to the c	euse(s) and ma	anner as s	steted.
HO.	he Fune pletely fi			sis of axamination end/o							
8	To the	29b. Signeture end title of certifier	and morning	er stateu.	29c Licer	nse number			29d. Date signe	d (Month	Day Year)
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		Janle	- UVS	us w	(N)	41	13		4-	16.	-77
		30. Name end eddress of person v	vho completed cause	of deeth (Item 23a) (Ty	rpe, Print)						
	10			10th St.		v. MD	21	1842			
	Ctoto	31. Dete filed (Month, Day, Yeer)		gistrer's Signeture	4 4	, , ,,,,					
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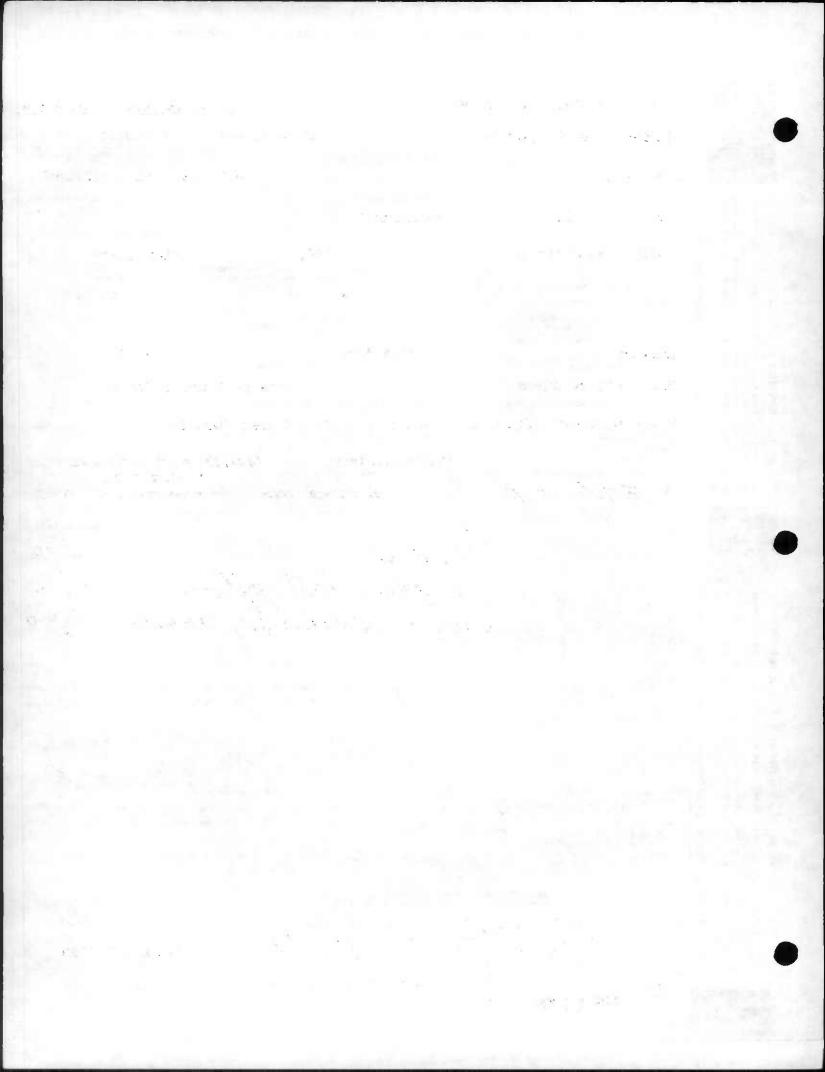
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician		ne (First, Middle, Las ret Gert		20110					2. Dete of De Month	eth Dey	Yeer	3. Time of Deeth
/Medical Examiner	4e Fecility Neme	(If not institution, give d Heart	street end numbe	er)				. City, Town, or L Cumber]		4c. Count		0200 A.M.
Funeral Director	5. Social Security 218–16–2 Usual Residence	Number 6. Se		Age (In yrs. I	ast birthday) Yrs.	If Under 1 Yes	ar	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De		9. Birth	plece (State or Foreign ntry) Maryland
wo m	10e. State	10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
the Maryler 28a-f show notified at	MD	Alle	gany	W	estern	port						1 ☐ Yes 2 🕱 No
or 28a-f	10e. Street end No	umber				10f. Zip Code	а			10g. Citlzan of	What Cou	ntry?
23a vit	26108 G	rovemille	r Road			-	156			United		
d 21215-UU2U filed within 72 hours effer deeth with the Maryland thygiene. ther than "natural", or items 23s or 28s-f show ont, the Medical Examiner must be notified at completed by Funeral Director		rried 2 Married	12. Wes Decede Armed Force 1 Yas 2 If Yes, Give Year or Dete	s? ☑ No		Vas Decedent of Yes, specify C ☐ Yes 2 1 N		panic Origin? (Sp. Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Specia	ck, White,	can Indien, , etc. nite
2 hou		15. Decedant's Edi	ucetion		16a. Deced	ant's Usuel Occ	cupati	ion		16b. Kind of E	Business/Ir	ndustry
Maryland 21215-0020 d 2 should be filed within 72 hours ef th end Mentel Hygiene. 7 is marked other than "natural", or treumatic event, the Medical Exam To Be Completed by F	Elementery/Sec Unknown		de completed) College (1-40	or 5+)		kind of work doi 20 NOT use ret emaker	ne dui ired)	ring most of work	ang	Н	ome	
Taryland 2 2 should be filed end Mentel Hygis is marked other eumatic event, in		(First, Middle, Last) Henry Tho	omas				1	18. Mother's Nam Isabel		, Maiden Sume uckie E		
ges 1 en t of Heal if Item 2 or other	Della M 20e. Method of Di	Cremation 3 □	Daughte	20b. P	Rt. 5 lace of Dispo	Box 1 silion (Neme of netory or other p	47	Keyse	ral Route Numb T, WV26 Dete	97. City or Town 2726 20c. Location	. Stete, Zi	own, State
Baltimore, permit. Peges 1 er Department of Hea Important: If Item any Injury or other pnce.		5 ☐ Other (Specify)		Ph	22	Mame end Add	dress	of Fecility al Home	11	Wester 1 Churc sternpo	h St.	
	One Post Sales	tha diseese, or comp	elications that saw	and the death							IL, P	Approximete
SOX 68760, th certificate be executed the certificate be executed the certification and ruse as the buriel-transit and the certification and the certifica	disease or condition resulting in death, Sequentially list of if eny, leading to cause. Enter Unc Cause (Disease or that infliated even resulting in deeth)	conditions, immediate derlying or injury	b	Due to (or	as a consequence of the conseque	uence of): Le disconnection of the connection o	ev tua	nt go	ailen inf a	e- peripe		2 yrs
2 E 2 E	Part II. Other sign	ificant conditions co	entributing to death	h but not resu	ulting in the u	nderlying ceusa	givan	n In Pert I.		9		to the cause of death?
rdS, P., quires that the signed by und be detected by Ph.										Yes 2□ No an autopsy	24b. V	Vare autopsy findings
The law requires that the dea sets hes been signed by the et page 2 should be detached for Completed by Physici									perf	Yas 2 No	0	vellable prior to ompletion of ceuse f daeth?
Vital I	25. Wes cese refe	erred to medical						28. Plece of Dea				
hysicie hysicie his cert il direct	exeminar?	No	Hospitel: 1 // Inpe	atient 2	ER/Outpatier	t 3 DOA	Other			idence 8 🗆 Ot	ther (Spec	ify)
After the funeral fune	27. Manner of Dec 1 (A Natural 2 Accident	5 Pending Investigation		njury Day Year)	28b. Time of Injury	28c. lr		et ? es 2 No		how injury occu		
2 5 2 9 O	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Piece of	Injury - At ho etc. (Specify	me, ferm, str	eet, fectory, offi	ca		28f. Location City or To	(Street and Num wn, Stete)	ber or Rui	ral Route Number,
the Hospital or hin 24 hours efte the Funeral Dir npletely filled in Aedical Cert	29e. Certifier (Check only one)	1 Certifying Phy 2 Nedical Exam		s of examinat		restigation, in m	y opi	nion, deeth occur				
To the Within	29b. Signature en	d title of central	110	2		29c. Lice	ense i	1117		29d. Date sign		
3	30. Name end edd	iress of person who a	90 Ma 32. Regi	in St	23e) (Type,	Pring	eri	port	MD	APRIL 2156	2	

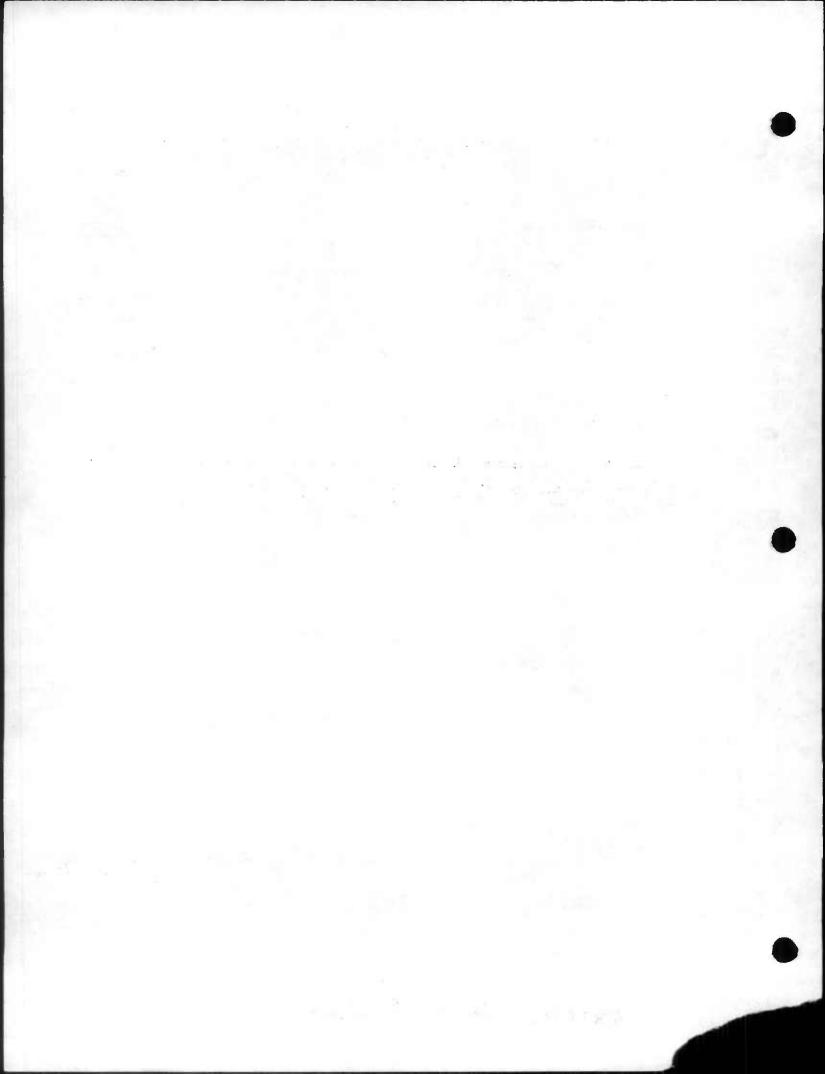


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Elizabeth Mary Gordy April 14, 1999
4b. City, Town, or Location of Death 4c. County of Death /Medical 2:30 PM 4a Facility Name (If not institution, give street and number) Examiner Salisbury Center: Genesis ElderCare Salisbury MD Wicomico If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 2 F 79 Yrs. Director 4/9/1920 Maryland <u>219-14-4610</u> Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Wedical Examiner must be notified at Director 1 DXYes 2 □ No Salisbury Wicomico MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA death v Funeral 200 Civic Ave 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours efter 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: p 3 ⊠ Widowed 4 □ Divorced white Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) shirt factory seamstress 6 other permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 Ie marked othe any Injury or other treumatic event blace. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) 86 Pearl Taylor 2 Walter Johnson, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30439 Zion Rd., Salisbury, MD 21804 Shirley Pellegrin (daughter) 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) enternment 4/19/99 Salisbury, MD Wicomico Memorial Park 22. Name and Address of Facility Holloway Funeral Home 21. Signature of Funeral Service Licensee M01051 Chompson 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Robold Aut Smoke /Medical Immediate Cause (Final disease or condition resulting in death) Examiner physician and s the bunal-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760 Physician/Medical Due to (or as a consequenca of) **US9 BS** aftending for use as P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? g g á 1 Yes 2 No 3 Probably 4 2 Unknown signed t Records, by 24b. Were autopsy findings available prior to Completed 24a. Was an eutopsy parformed? peen completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 2 No certificats Division of Vital Attending Physician: director, 8 25. Was case referred to medical 26. Placa of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this funaral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1- Naturai deeth. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 29a. Certifier 1 critifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 39813 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) since Solis mis 21804 MATKINS Kentta 31. Date filed (Month, Day, Year) 32. Registrar's Signature

APR 1 6 1999

State

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Nama (First, Middle, Last) Day **Physician** 16 Clarence Hubert Grant, Jr. 04 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner 6955 Powellville Road Willards Wicomico 6. Sax. 1 MM 2□ F If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min Months Deys Hours Yrs. 01/15/1922 Director 213-12-3203 Usuel Residence of Decedent 10c. City, Town or Location the Merylenc 10a State 10h County 7 is marked other than "natural", or items 23s or 28s-f shot traumatic svent, the Modical Examine, must be notified at Director Salisbury MD Wicomico ENC 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 213 Lakewood Drive 21804 USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 2 Yes 2 □ No If Yes, Give Yaer or Detes: 42 − 45 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 1 □ Never Married 2 □ Married Specify: White Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiene. Elemantary/Secondary (0-12) Collage (1-4or 5+) Management Printing 12 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Nama (First, Middle, Last) 12 should be fi h and Mentel H Clarence Hubert Grant, Sr. Emily Ellen Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Peges 1 end 2 ment of Health ar nt: If item 27 le 1 y or other from 213 Lakewood Drive, Salisbury, MD Clarence H. Grant, III (son) Saltimore, 20b. Pleca of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 Cremation 3 ☐ Removal from State permit. Pege Depertment of important: If any injury or 4 Donetion 5 Other (Spacify) Salisbury Crematory Salisbury, MD 21801 22. Name and Address of Fecility Holloway Funeral Home, 501 Snow Hill Rd. 21. Signeture of Funeral Servica Licansee Michel A Dean m01129

23a. Pert1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line.

Due to (or es e consequence of):

RESPIRATORY

Physician /Medical Examiner

Immediate Cause (Final disease or condition resulting in death)

physician end the buriel-tren certificate be exec 98 esn signed by the e pege 2 certificate

Examiner Physician/Medicai by Completed 10 Certification:

Records, P.O. Division of Vital After efter deeth. 24 hours efter decide Funerel Director ò To the Hosp within 24 hor To the Fune completely fi

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings evallable prior to 24a. Wes en eutopsy completion of cause of daeth? 1 Yes 2 No 1 Tyes 2 No. 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending 1 Neturel 1 ☐ Yes 2 ☐ No Invastigation 2 Accidant 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Sulcide 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To tha bast of my knowledga, daeth occurred et the time, date end place, end due to the ceusa(s) and manner es steted. (Check only one) 2 Madical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end pieca, end due to the ceuse(s) and mennar stated.

29c. Licensa number

St., Salisbury, MD 21801

129168

3. Time of Deeth

0800hrs

10d. Inside City Limits

1 Yes 2 No

Birthplece (State or Foreign Country)

Maryland

Black, White, etc.

21804

29d. Date signed (Month, Day, Year)

21801

Approximata Intervel Batwaan Onset end Death

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Salisbury, MD

1999

State Registrar

Medical

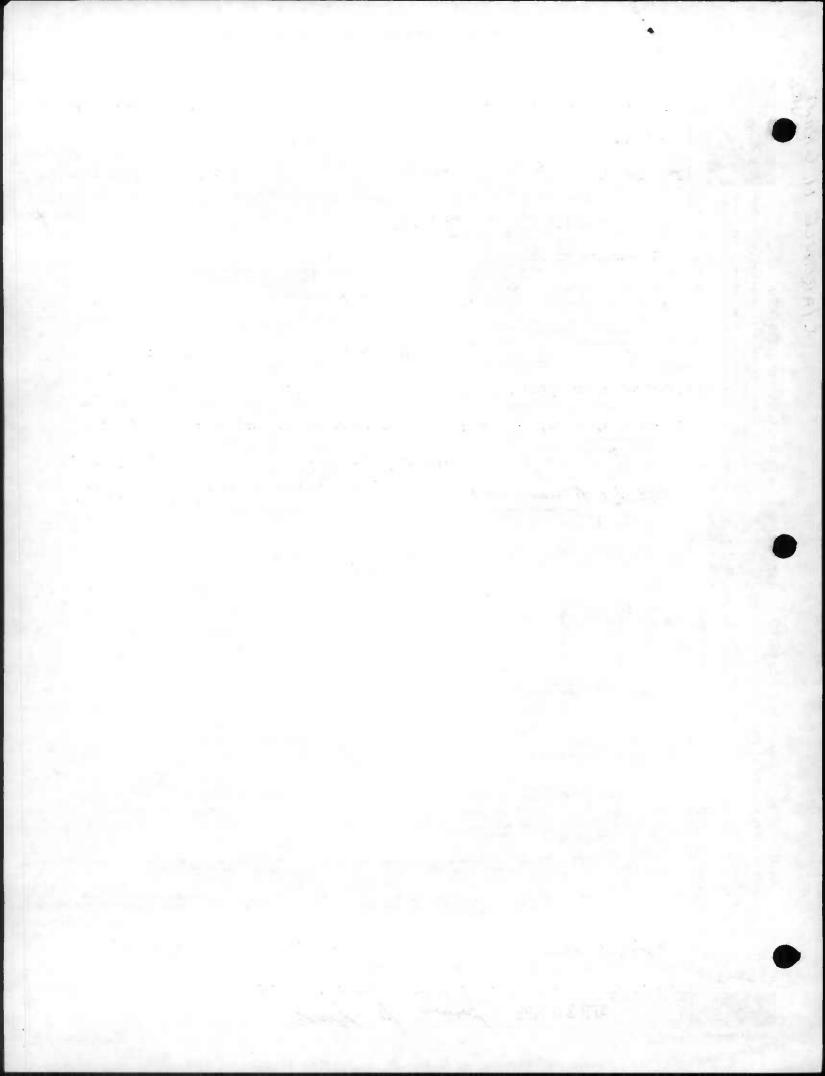
29b. Signeture and title of cartifier

salle

30. Name end eddress of person who complated causa of death (Itam 23a) (Type, Print)

Robert Allen, MD, Power Line, St 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 0 1999

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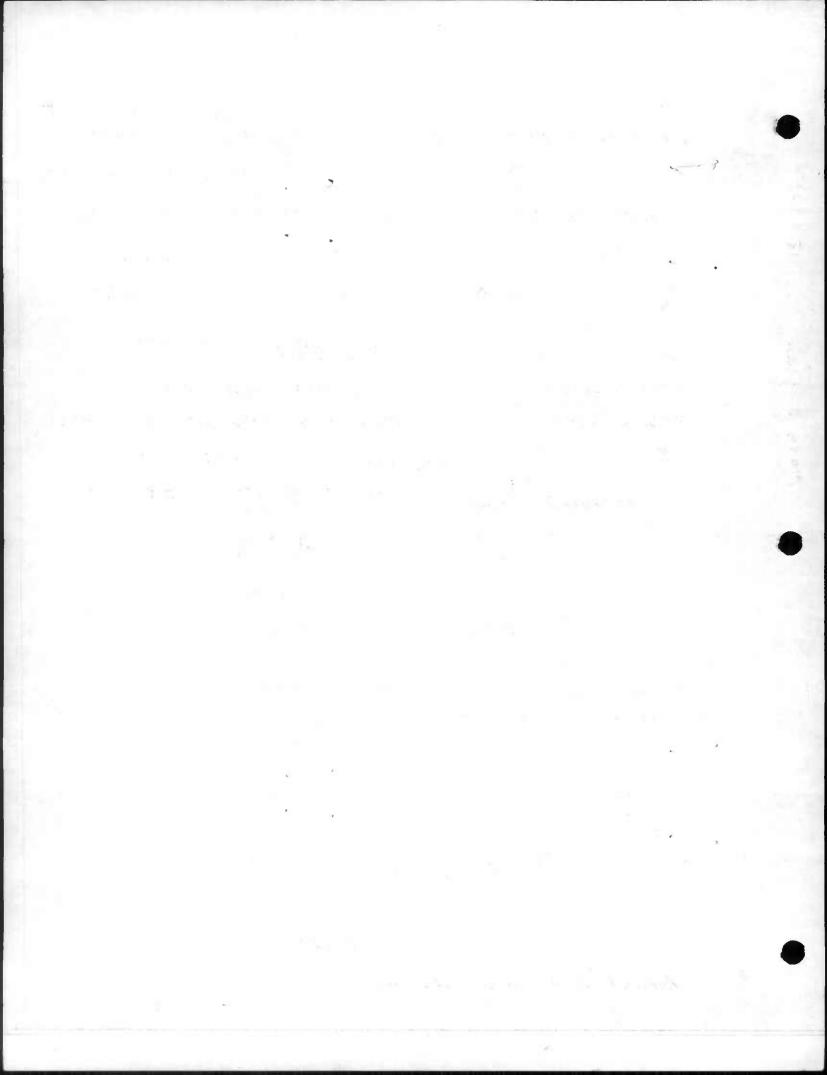


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** MARY ADLINE GREEN 0 234 199 4b. City, Town, or Location of Death /Medical 4a. Facility Name (If not institution, give street end number) 4c. County of Deeth WICOMICO Examiner SALISBURY PENINSULA REGIONAL MEDICAL CENTER 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Dey, Year) 5 Social Sacurity Number 6 Say Birthplece (Steta or Foreign
Country) Funeral. 1 M 2 TF Yrs. Director 221-18-5024 85 MAY 6 1914 LAUREL DEL. # - green 221-18-5028 Usuel Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at the Maryle DELAWARE SUSSEX 1 Yes 2 No Director LAUREL 10e. Street end Number 10f. Zip Code_ 10g. Citizen of Whet Country? 507 WEST 6th 19956 USA 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 □ Never Married 2 □ Married Specify: BLACK 1 ☐ Yas 2 🛣 No Specify: by 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene, important: If Item 27 is marked other than thy injury or other traument. Elementary/Secondary (0-12) Coilege (1-4or 5+) HOMES DOMESTIC WORKER 9th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be JAMES ROBERTS 0 MARY ANNIE UNK 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUSSELL GAINES ROUTE 1 BOX 55 BRIDGEVILLE DEL. 19933 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from Stata 4-15-99 LAUREL DEL 4 ☐ Donation 5 ☐ Other (Spacity) NEW ZION 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility YOUNGD FUNERAL HOME 308 N. FRONT ST. 23e. Part 1. Enter the disease, or complications that county the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one angle on each line. rareve Approximate Onsat end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical insufficiency Examiner Due to (or es e consequence of): Due to (or es e consequence of): burial-transit Sequantially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last be axec physician s the burial Box 68760, phrol chtular Physician/Medical Due to (or as a consequence of): The law requires that the death cartificate attanding Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part i. 23h. Did tobacco use contribute to the cause of death? P.0. á 1 □ Yee 2 ☑ No 3 Probably 4 Unknown signed t appr fi a hulysm Records, by 24b. Were autopsy findings aveilable prior to completion of causa of deeth? 24a. Was en eutopsy performed? Be Completed peeu certificate has paga 20 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics 25. Wes case referred to medical 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No To 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Naturel 5 Pending Investigation s after death.
I Director: After in by the fundament 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straet and Number or Rurel Route Number, City or Town, Stete) 4 Homicide Certifying Phyelclen: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Deta signed (Month, Dey, Year) 153394 MO 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) SALISBUM, MO 106 Milfold ST. Anthony Frey M.J. 31. Dete filed (Mooth, Dey, Year), 32. Registrer's Signeture State APR 22 1000 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** April 19. Eugene Baker Grossnickle 8:45 P.M. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 11605 Robinwood Dr. Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 25, 1920 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In yrs. last birthdey) **Funeral** M 2□ F 78 214-14-6219 Yrs. Director Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner naut be notified at 1 ☐ Yes 2/X No Director Washington Hagerstown 10e. Street end Number 10f. Zip Code 10a. Citizen of What Country? ò 11605 Robinwood Dr. Items 23a U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Maritei Stetus 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 ò 1 ☐ Yes 2 ☐ No White 3 ☐ Widowed 4 ☐ Divorced Specify: "natural", 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Department of Health end Mentel Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, trails any Dines. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Raymond Grossnickle Myrtle Baker 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Helen V. Grossnickle (Wife) 11605 Robinwood Dr. Hagerstown, Md. 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 【XCremetion 3 ☐ Removal from State Smithsburg Crematory April 21, 1999 Smithsburg, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Carcinoma diseese or conditior resulting in deeth) Examiner Due to (or es e consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, ettending physician Due to (or es e consequence of): been signed by the e should be deteched it Pert il. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the cause of death? Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 No Other: 4 Nursing Home 2 1 Yes 5 Residence 8 Other (Specify) After this Medical Certification: 27. Manper of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Naturei 2 Accident 5 Pending Investigation death. 1 Yes 2 No efter death illed in by the 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homleide within 24 hours e To the Funeral D completely filled Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

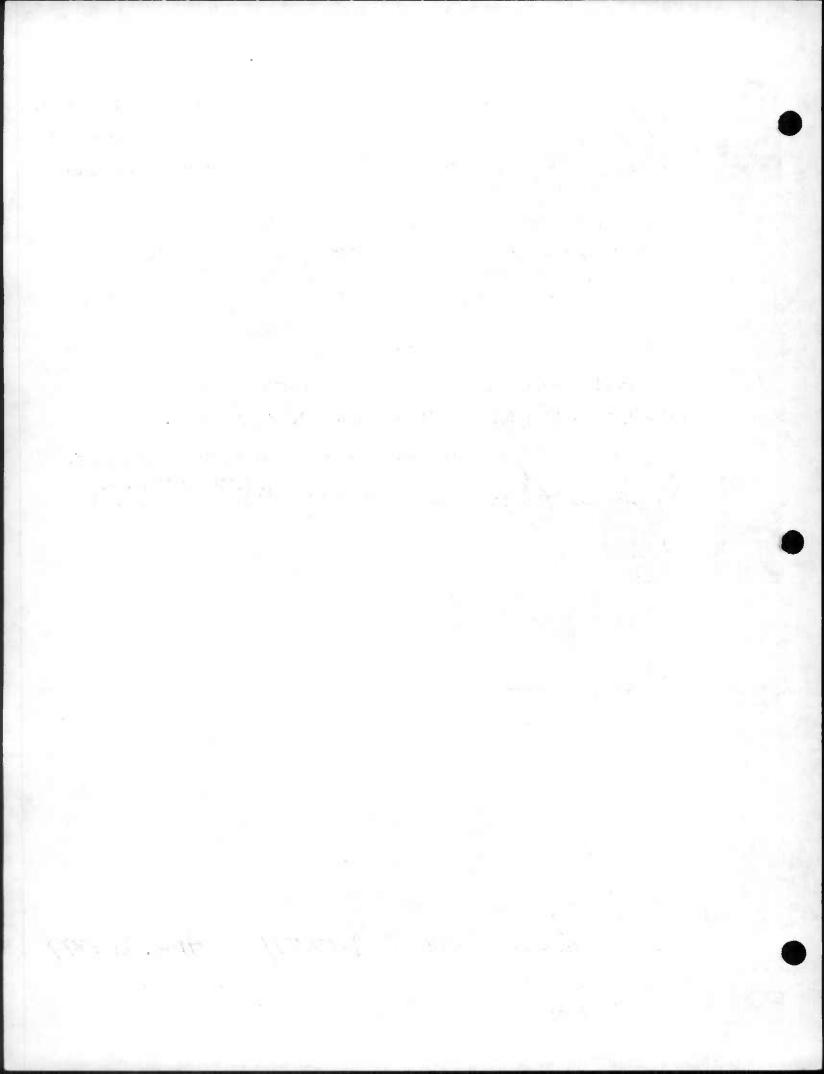
2 Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner stated. 29a. Certifier (Check only one) the 29b. Signature and affie of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Nemn and eddress of person who completed ceuse of death (Item 23e) (Type, Print) George Newman 11110 Medical Campus Rd. Hagerstown, Md. 21742

State Registrar 31. Dete filed (Month, Day, Year)

APR 2 2 1999

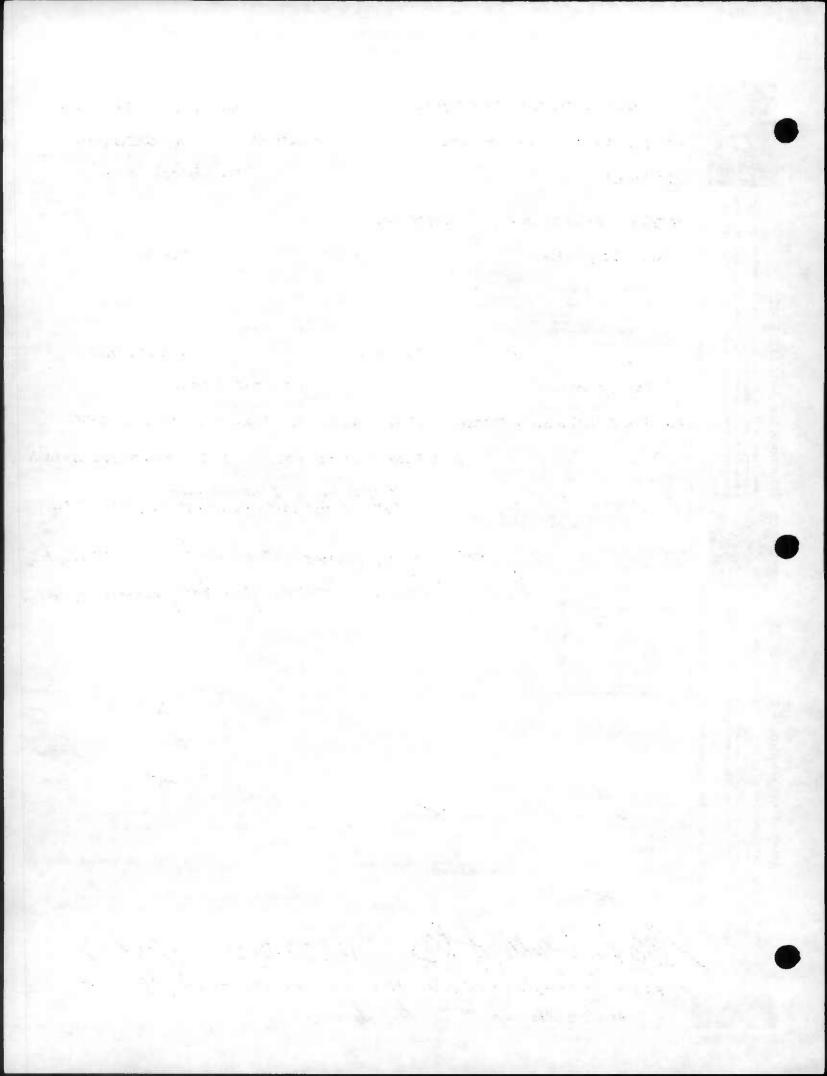
32. Registrer's Signature

Sparks



State of Maryland / Department of Health and Mental Hygiene 9

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		. Decedent's Neme (First, Middle, Las						2. Dete of Dee Month	th Dey	Yeer	3. Tima of Death
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/Medica Examine		e Fecility Nama (If not institution, give	e street and number))			4b. City, Town, or	Location of Deeth	4c. County	of Deeth	
		Shady Grove Adven	tist Hosp	ital			Rockvill	.e	Montgo	mery C	٥.
Funeral Director		Social Sacurity Number 6. S 217–32–3656 Suel Residence of Decedent	ex 7. Ag	ge (In yrs. la 5		If Under 1 Y Months Di	aar If Undar 24 Hrs ays Hours Min		, Yeer) , 1933	9. Birthpled Country Virgin	ca (Stete or Foreign 11a
and **	-	0e. Stete 10b. County		10c. City,	Town or Loca	tion				10d	. Inside City Limits
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urs of	by Fur	1. Marital Status 1. Naver Married 2. Married 3. Widowed 4. Divorced	12. Was Decedant Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	7		as Decedant as, specify	of Hispenic Origin? (Cuban, Mexican, Pue No Specify:	Specify Yas or No- rto Rican, etc.)	Specify	e - Americen ck, Whita, etc White	2.
72 hours	Completed	15. Decedent's Ed (Specify only highest gre	lucetion de complated)		16e. Deceder	nd of work d	one during most of w	orking	16b. Kind of Bu	siness/Indus	stry
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emit. Pages 1. Bepartment of He important: If Herr iny Injury or oth fice.	2	0e. Method of Disposition 1 Suriel 2 Cremetion 3 C 4 Donetion 5 Other (Specify		ce	ece of Disposit metery, creme Haven	tory or other	tery Apr.	21, 1999	20c. Location -		
ficete be physicials the bur	cal Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate couse. Enter Underlying Cause (Disease or Injury hat Initieted events resulting in deeth) Lest	b. Jon s c	Due to (or	es a conseque as a conseque as a conseque	ling (Coroner	y or f	ing Des	lan	yuse V
death ce	SCI	Part II. Other significant conditions of	ontributing to death b	out not resul	Iting in the und	lerlying ceus	e given In Pert I.	23b. Dld t	obacco use co	ntribute to ti	he cause of death?
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he law requires that the e has been signed by the ege 2 should be deteche	Completed by								en eutopsy rmed?	aveile	e autopsy findings eble prior to pletion of ceuse seth?
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Mospital or A hours after Funeral Dir mety filled in				of examineti			he time, date end plac my opinion, deeth occ				
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State	5	31. Date filed (Month, Day, Year)	d2. Registr	rar's Signat		-			1	1	
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					Ce	rtificate	of De	ath		Reg. No.		
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Exar	niner	4e. Fecility Neme (If not institution, gr							Location of Death			
2.5		Colton Villa Nur 5. Sociel Security Number 6.		1 e 7. Age <i>(In yrs. la</i>	ast hirthday	If Under 1 Y		lagers Under 24 Hr			ashin	<u> </u>
Funer Direct	_		1 ⊠ M 2□ F	83	Yrs.			ours Mir		1915	Cour	olece (Stete or Foreign otry) ginia
wo m		10a. State 10b. County		10c. City	, Town or L	ocation					1	Od. Inside City Limits
the Mary 28a-f sh	Director	Virginia Fred	erick	Win	chest		4.					120 No 2 No
23a or		722 Van Fossen S	treet			10f. Zip Co	22601			10g. Citizen of USA	Whet Cour	itry?
2-0020 72 hours effer death with the Maryland natural;, or Items 23a or 28a-f show deal Exercites must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed For 1 24 Yes If Yes, Give	2 □ No e		Was Decedent If Yes, specify (1 ☐ Yes 2 🗷	Cuben, M	nic Origin? (lexican, Pue pecify:	Specify Yes or No rto Rican, etc.)		ce - Americ ck, White, y: w	
A 1A 13-0020 d within 72 hours eff giene. r than "natural", or , in the call Exami		15. Decedent's E	Year or Da	ites:	18e. Dece	dent's Usuel O	ccupetion			16b. Kind of B	usiness/Inc	dustry
within 72 h ene. than "natu	Completed	(Specify only highest gi		-4or 5+)	(Give life.	kind of work do DO NOT use re	one durin etired)	g most of w	orking			,
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		Barbara Franks 20a. Method of Disposition	daught			Mont V		Ave.	, Hagers			
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eparti portu	SUCE	21. Signeture of Funerel Service Lice	nsee	1	1 2	2. Name end A	ddress of	Fecility	MINNICH	FUNERAL	L HOM	E
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eeth certificate be executed ettending physician end for use es the bunal-transit	edical Examiner	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events	b. <u>CHN</u>	Due to (or	es e consec	quence of):	710	EA	IRWAY	DISIB	AST=	loycau.
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To the Hospital or Attenc within 24 hours effer deet To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Pl	nyelcian: To the baseliner: On the baseliner	sis of examination	ledge, death on end/or in	n occurred et th vestigation, in r	e time, d	ete end plac n, deeth occ	e, end due to the urred et the time,	ceuse(s) and m date end place,	enner es si end due to	eted. the ceuse(s)
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	tate	NA ANZAN 31. Dete filed (Month, Dey, Year)	32. Re	dictrar's Signetu	168 I	1100 8	(10)	121	HAUSICS	TOWN	UTD	21740.
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician EVELYN** HORNSBY 930 1999 Dril /Medical 4c. County of Deeth 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1□M 2☑F 76 Yrs. **Director** 214-16-4552 September 20,1922 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 X Yes 2 ☐ No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 428 Coles Circle 21804 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Bieck, White, etc. treumstic event, the Medical Examiner filed within 72 hours efter 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 8 1 ☐ Yes 2 X No Specify: White ģ 3 Widowed 4 □ Divorced 'naturel', Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Domestic 11 Homemaker other 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Pages 1 end 2 should be fill iment of Health and Mental Hiant: If item 27 is marked oth Be Harrison E. Smith Rosa E. Niblett 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Depertment of Health a Important: If Item 27 is eny injury or other tree Kim E. Harrington/Daughter 7204 E. Ranier Dr., Parsonsburg, MD 21849 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4/12/99 Salisbury, MD Wicomico Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Enter the disease, or complications that caused the correct to the course of the correct to the correct that cause on the correct to the corr eath. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximete Intervet Betw Onset and Death **Physician** /Medical Immediate Ceuse (Finat INFARCT HENDRRHIGE 24 hours disease or condition resulting in deeth) **Examiner** Due to (or es a consequence of): Examiner HYPERTENSION The law requires that the deeth certificate be executed Sequentiatly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Physician/Medicai Due to (or as a consequence of) signed by the attending Pert tl. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. should be detached 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown by Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings evailable prior to Deed completion of cause of deeth? 200 No certificate 1 ☐ Yes 2 ☐ No of Vital director 25. Was cese referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No Certification: To 1 Inpatient 2 ER/Outpefient 3 DOA this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftar Division or Attending 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No ours after death.

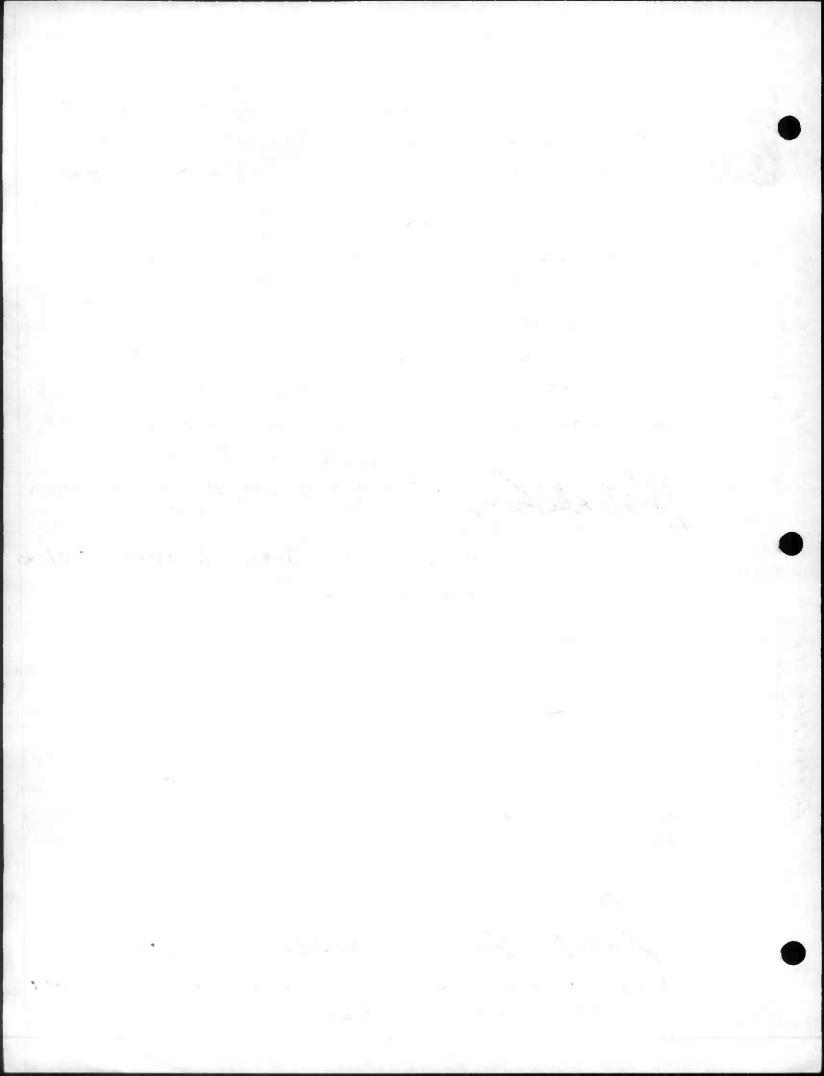
neral Director: A
filled in by the fo investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral C completaly filled Hospital Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner stated. 29e. Certifier Medicai 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) D36576 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 560 RIVERSIDE DR SALISBURY MD 21801 TROUTZOND 31. Dete filed (Month, Dey, Year) APR 1 3 1999 32. Registrer's Signature

DHMH 16 Rev 6/95

State Registrar

Evelyn Hornsby



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Death **Physician** Month LILLIAN **ESTHER** HITT.T. APRIL 16, 1999 4c. County of Death /Medical 3:28 PM 4a. Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore H Under 1 Year If Under 24 Hrs. 8. Deta of Birth 9. Birthplece (Steta or F Months Days Hours Min. JULY 29, 1916 TENNESSEE 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (Steta or Foraign **Funeral** 1□M 2DTF 222-05-3704 82 Yrs. Director Usual Residence of Decedant Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland sent of Mealth and Mentel Hygiene. 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits BLADES Yas 2 No Director DELAWARE SUSSEX 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? "natural", or items 23a or 14 WEST 3rd STREET 19973 AMERICA by Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 27 No If Yas, Giva Yaar or Detes; Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - Amarican Indian, Black, White, etc. 11. Meritel Status 1 ☐ Nevar Married 21X Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 € No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed traumatic avant, the Medical 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry and Mentel Hygiene. Elementery/Secondary (0-12) DOMESTIC Collage (1-4or 5+) HOMEMAKER 9YRS. 17. Fether's Nema (First, Middle, Last) 18. Mothar's Name (First, Middla, Maldan Sumama) Be **ASBURY** LEE HORN POLLY JANE INGLE HORN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) nt of Health e If Item 27 is or other trac HARLAN E. HILL 14 W. 3rd STREET BLADES, DELAWARE 19973 20b. Plece of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 □ Cramation 3 □ Removel from Stata Department of 4/20/99 BLADES, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) BLADES CEMETERY 22. Name and Address of Facility WATSON-YATES FUNERAL HOME FRONT & KING STREETS SEAFORD, DELAWARE The disagsa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, gert fally 6. List only one cause on each line. Physician /Medical Immediate Cause (Pinal MYOCARDIAL INFARCTION ONE WEEK disease or condition resulting in death) Examiner Dua to (or as a consequance of) Physician/Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dua to (or as a consequence of): The lew requires that the death certificate be eas P.O. Box 68760, 8 Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown PERIPHERAL VASCULAR DISEASE Records, by 24b. Wara autopsy findings available prior to complation of cause of death? Be Completed 24a. Was an autopsy performed? certificate hes 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was casa rafarred to medical examinar? 26. Placa of Deeth (Check only ona) Hospital: 1 Inpatient 2 □ ER/Outpatiant 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yas this 27. Manner of Death 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred After 5 Panding Invastigation To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicide 6 ☐ Could not be datamined 28a. Placa of Injury - At home, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 I Homiclda 12 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar es stated.
2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, daath occurred at the tima, data and place, end dua to the causa(s) end mannar stated. 29a. Cartifian 29b. Signeture and titia of certifier 29c. License number 29d. Deta signed (Month, Day, Year) 04-16-99 D30263 30. Nama and address of person who complated cause of deeth (Item 23a) (Type, Print) FRANCIS, KHOO, M.D., 7601 OSLER DRIVE, TOWSON MARYLAND 21204 31. Deta filed (Month, Day, Year) 32. Registrar's Signeture State APR 1 9 1999 Registrar

DHMH 16 Rev 6/95

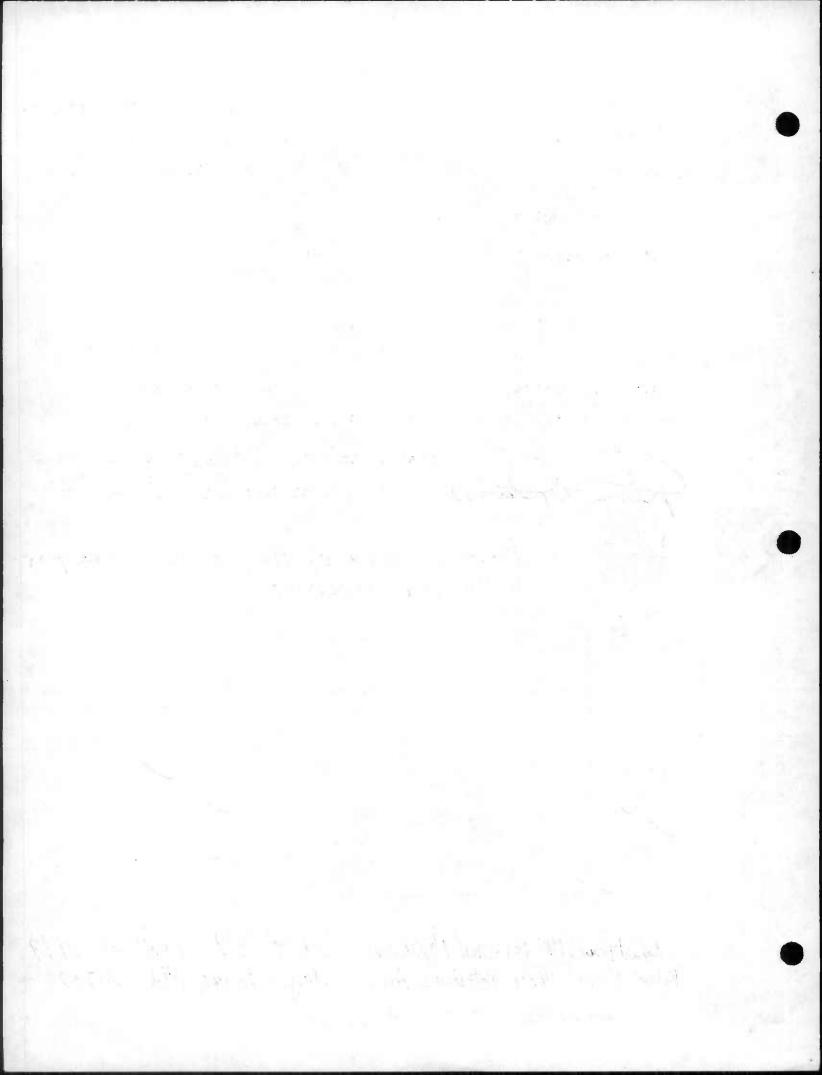
State of Maryland / Department of Health and Mental Hygiene 9 9 4 3 3 5

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Man	ţ	MD	Wicon	nico	S	harptov	wn							1 ☐ Yes 2X N
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th wit	a o	P.O. H	3ox 411				2	1861	ı			USA		
dea	Funerai	11. Marital Status		12. Was Deced	lent Ever in U	J,S. 13.				gin? (Sp	ecify Yes or No Rican, etc.)	- 14. F	ace - Americ	
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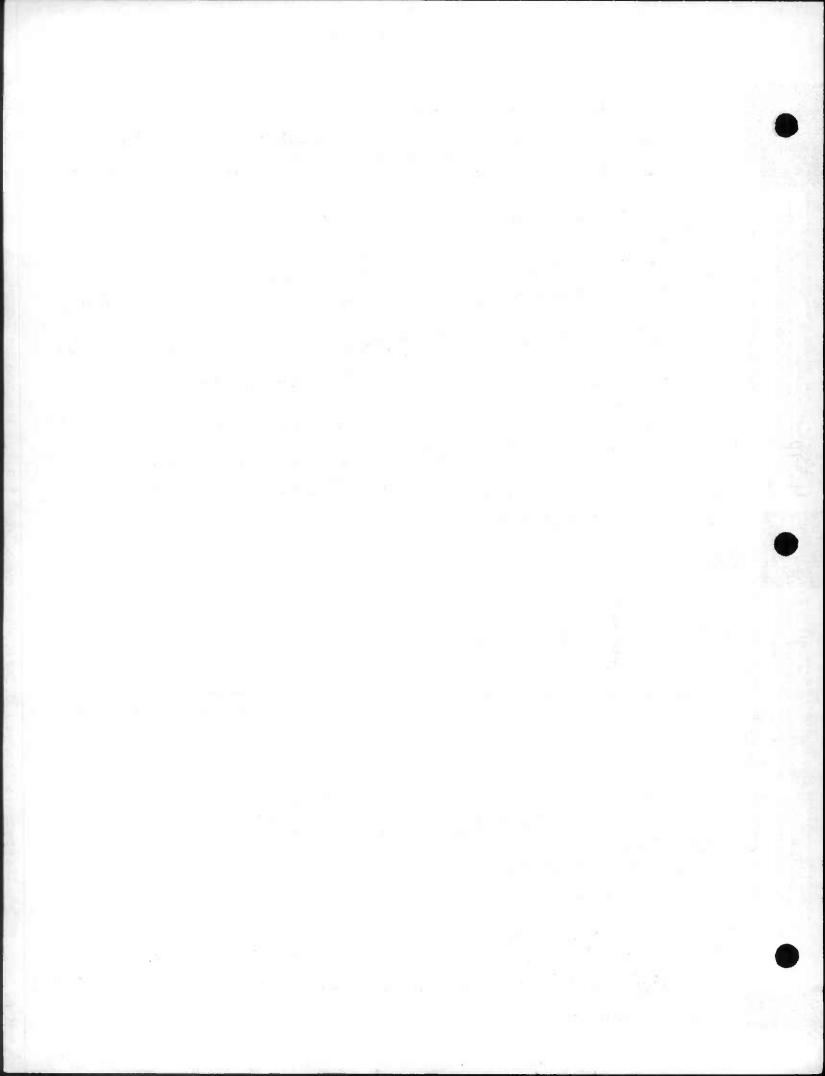
State of Maryland / Department of Health and Mental Hygiene 9 4 3 3 6

						Ce	rtificat	e of	Death		Re	eg. No.		
	Dhoole	·	1. Decedent's Name (First, Middle	, Last)							2. Date of Daet	h		Time of Death
	Physic /Medi		William Fra	nklin H	lopkins						April	20, 199	99 8	;30A.M.
	Exami		4a. Facility Nama (If not institution 1258 Frederi		umber)				4b. City, To		ocation of Death	4c. County of Washi		n
	_e Funeral Director		5. Social Security Number 214-09-9223	6. Sex X ☐ M 2☐ F	7. Aga (In yrs. last	birthday) Yrs.	If Unda Months	Days		24 Hrs. Min.	8. Data of Birth July 8	,1917 P	Birthpleca Country)	(State or Foraign
	pur *		Usual Residence of Decedent 10a. State 10b, County		10c. City, To	oum or Lo	nation							
	8s-f show	Director	Md. Wash:	ngton			stow	n				•		nside City Limits Yes 2/1 No
	vith th	Dire	10e. Street end Number				10f. Zip	Coda			10	0g. Citizen of Who	et Country?	
	ss 23	eral	1258 Freder		edent Ever in U.S.	40.1	Man Dann	dant of	21740		- 14 . 34	U.S.1		
050	ours efter d	by Funeral	1 ☐ Navar Marriad ※ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed F	orces? Ž⊟ No ive		f Yes, special Yes				ecify Yas or No- Ricen, etc.)		Amarican In White, etc. Whi	
21215-0020	filed within 72 hours efter death with the Maryland Hygiene. ther than "natural", or flams 23a or 28a-f ahow ont, the Medical Exament than be notified at	Completed	15. Decadent (Specify only highas Elementary/Secondary (0-12)	s Education t grade completed) College ((Give	dent's Usua kind of wo DO NOT us Disp	rk done se retire	during mos ed)	t of work	ring	16b. Kind of Busin	ness/Industry	
	be filed with ital Hygiena. d other than event, the		1 2 17. Fathar's Nama (First, Middle, I	aet)			DISP	acc	1	r'o Nam	e (First, Middle, N		Lroad	
Maryland	of table	To Be	Jacob M. Ho											
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	of Health a ltern 27 is other train		Sara B. Hop	ins (Wi			_				lagerst			-/
Baltimore,	Pages 1 en nent of He net: If Item		20a. Method of Disposition 1 □ Burial 2 A Cremation 4 □ Conation 5 □ Other (Sp	3 □Ramoval from		tery, cren	netory or o	ther ple		V	April 21,1999	20c. Location - Cit		
Balti	permit. Pages Depertment of Important: If II any Injury or one		2) Signature of Funeral Service L	/	Tes .	22	. Name en	d Addr	ess of Facilit	у		5 Bradl	oury	Ave.
x 68760,	bhysician exacuted exacuted attending physician and attending physician and to the build-transit its control of the physician and the physician are at the p	n/Medical Examiner	immediata Cause (Finel disaase or condition resulting in death) Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that intitated events resulting in death) Last	a. Ac	Dua to (or as	a consaq	uance of):	a tos	of tase	the s	Colo	n	ON	e Year
.O. Bo	the the	Physician	Pert II. Other significent condition	s contributing to de	eath but not resulting	g in the ur	nderlying c	ause gi	ven in Part I.		23b. Did tol	bacco use contri		
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	ysician: The is certificate director, pag	Bec	25. Was case referred to medical						26. Place	of Deat	h (Check only ope			
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	al or Atta s after de il Directo ed in by ti	Certification:	3 Sulcide 6 Could no determin	ed 286. Place	of Injury - At homa, ng, etc. (Specify)	farm, stre	et, factory	, office			28f. Location (Str. City or Town,		or Rural Rou	te Number,
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	To the within To the Complex C	M	29b. Signature and title of cartifier 30. Name end eddress of person w	MD Per	Sonol M	YSICA i) (Type, F	ian	. Licen:	se numbar	4-	359 29	d. Date signed (A	2/	1999
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	Sta Registr	i.e	31. Date filed (Month, Dey, Year) APR 2		egistrar's Signature	/	9.	100	who !					



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				State of Maryland / De	Certificate of			eg. No.			
	т	Physic	ian	1. Decedant's Nama (First, Middle, Last) Elsie Mabel Horst			2. Data of Deat) 9°9′	3. Tima of Deat	
4		/Medi	cal	Elsie Mabel Horst 4a. Facility Nama (If not institution, give street and number)		4b. City, Town, or L	April			4:28 P.	Ţv
		Examir	ner	Homewood Retirement Center		Williams		4c. County Wash		on	
		Funeral Director		5. Social Security Number 6. Sax 1 M 2 X F 88 Yr.	Months Days		8. Data of Birth (Month, Day, May 31,			laca (State or Fore	∌ <i>ig</i> n
		and		Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town of	or Location				10	0d. Insida City Lim	nite
		Maryl H sho	tor		Hagerstown	n				∜ Yas 2□	
		or 28	Funeral Director	10e. Street and Number	10f. Zip Coda		10	0g. Citizan of V	What Coun	try?	
		ath w	ral	1064 View Street	21740			USA			
		item item	-une	11. Marital Status 12. Was Decedant Ever In U,S. Armed Forcas? 1 ☑ Nevar Marriad 2 ☐ Married 1 ☐ Yas 2 ☑ No	 Was Decedant of If Yas, specify Cul 	Hispanic Origin? (Sp ban, Maxican, Puarto	ecify Yas or No- Rican, atc.)		e - Amarica ck, Whita, a		
	020	al', or	þ	3 ☐ Widowed 4 ☐ Divorced Yaar or Datas:	1 ☐ Yas 2 ☑ No	Specify:		Specify	. Whi	te	
	5-0	72 ho natur	Completed	15. Decedant's Education 16a. D (Specify only highast grada complated) (0	ecedent's Usual Occu Giva kind of work done fa. DO NOT use ratin	apation a during most of work	ing	16b. Kind of Bu	usinass/Ind	lustry	
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	Maryland 21215-0020	2 should be filed within 72 hours after death with the Maryland and Mental Hygiena. Is marked other than "natural", or items 23a or 28=f show reumatic event, the Medical Exercited roust be notified at	Be C	17. Fathar's Nama (First, Middla, Last)		18. Mothar's Nam			na)		
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9	ē,	f Heal f Heal starn 2 other		20a. Mathod of Disposition 20b. Place of D	hisposition (Nama of cramatory or other plant			20c. Location -			
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0	Salt	pemit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mental Hygiena. Important: If Itam 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic svant, the Medical Examtron must be notified at once.		21 Spriature of Funeral Service Licepsee	22. Name and Addi Gerald N.	ass of Facility Minnich	305 N.	Potoma	ac Sti	reet	
	-	20540		Sixe () I know	Funeral H	lome	Hagers	town, M		and 2174	0
		Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one ceuse on each line.	t antar tha moda of dy	ring, such as cardiac	or raspiratory arra	ist,		Approximata Interval Between Onsat and Death	
	7	/Medical		Immediata Causa (Final diseasa or condition	Cano	105				100	
	ш	Examiner	-	rasulting in death) a. Dua to (or as a con						700	
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)	ó	ificate be axecuted physician and as the burial-transit		Sequantially list conditions, if any, laading to Immadiata cause. Enter Undarfying Cause (Disease or Injury	isaquanca oij.						
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	-	0 0 0	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the	na undarlying causa g	ivan In Part I.	23b. Did to	bacco use cor	ntribute to	the cause of dea	rth?
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+	ds,	8 6 8	d by	Dalat			24a. Was a	n autoney	24b We	era autopsy finding	ne
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II	Division	il or Attending F after death. Director: After d in by the funer	Certification:	3 ☐ Suicida 6 ☐ Could not be datarmined 28a. Placa of Injury - At homa, farm building, atc. (Specify)	straat, factory, office		28f. Location (Str City or Town	reet and Numb	er or Rura	Routa Number,	
		pital o	-		lasth account to the	ina data and	and disc to the	auna (s) =			
		To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifiar (Check only one) 1 ▼Certifying Physician: To tha best of my knowledga, d 2 ■ Medical Examiner: On tha basis of axamination and/c and manner stated.	aath occurred at tha t or invastigation, in my	ima, data and placa, opinion, daath occur	and dua to tha ca red at the tima, da	iusa(s) and me ate and place, a	anner es stand due to	eted. the cause(s)	
		To th To th comp	Me	29b. Signatura and little of Certifier	29c. Licar	sa number	29	9d. Data signed	d (Month, L	Day, Year)	rind file
				1//()	D	2680	6	41.	15/5	3	
				30. Name and because of berson who completed cause of death (Itam 23s) (Ty	pe, Print)	e Hu	oscila	h	20	2/74;	>
		Sta Registr		31. Data filed (Month, Day, Year) ADD 1 5 1000 32. Registrar's Signature	4		(W)				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Defe of Death 3. Tima of Death Month **Physician** Lela Joene Herring April 1 1999 4c. County of Death 0155 /Medical 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Data of Birth Month, Day, Year May 31, 1919 9. Birthpleca (Stata or Foraign **Funeral** Country) Texas 1□M 2√F Months Days Hours 79 462-36-5759 Director Usuel Residence of Decedan with the Maryland 10c. City, Town or Location 10d. Insida City Limits 10a. Stata 10b. County 7 is marked other than "natural", or items 23a or 28a-f show trsumstic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Washington Hagerstown 10f. Zip Code 10g. Citizan of What Counfry? 10e. Streef and Number 11331 Youngstoun Drive 21742 USA Funeral death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Rece - American Indian, Black, Whita, atc. 72 hours after 1 ☐ Navar Marriad 2 ☐ Married Specify: White 1 Yas 2 No Specify: þ 3 ☐ Widowad 4 ₺ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grada complated) Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Clerk Rosen's Dept. Store marked other 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 Is marked of any Injury or other trsumatic eve Car1 Bassett Lela Logan 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Carla A. Tabler 11331 Youngstoun Drive Hagerstown, Maryland 21742 Daughter 20b. Place of Disposition (Nema of cematary, crematory or other place) 20a. Method of Disposition Defe 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Rose Hill Cemetery 4/14/99 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specity) 21. Signatura of Funaral Service Licansee Gerald N. Minnich 305 N. Potomac Street nund Funeral Home Hagerstown, Maryland 21740 23a. Part 1. Enfer tha disaese, or complications thef caused the deeth. Do not anter tha moda of dying, such es cardiac or respiratory arrast, shock, or haart failura. List only ona causa on aach lina. Approximata tntarval Batween Onset end Deeth **Physician** /Medical Immediate Cause (Final W126-9 disaasa or condition resulting in deeth) Examiner Examiner Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Ceuse (Disease or injury that initiated avants rasulting In daath) Last Dua to (or as a consequence of): physician s the buttal Box 68760 2 Physician/Medicai Dua to (or as e consequance of) Reliva wowe Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the cause of death? Division of Vital Records, P.O. 100 dosolde signed by d 1 → 160 2 No 3 Probably 4 Unknown þ bowel disease 24b. Wara eutopsy findings availabla prior to complation of cause of daeth? Completed 24a. Was an autopsy is certificate h director, page 1 Yas 2 No 1 Yas 2 No 25. Was case rafarred to madicel Be 26. Pleca of Daath (Chack only one) axaminar? Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No Certification: To 1 Impatient 2 ER/Outpatiant 3 DOA 2 Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Deeth 28b. Tima of 28d. Describe how injury occurred Attec 1 Netural 5 Panding invastigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicida 6 Could not be detarmined 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the causa(s) end menner es steted.

2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and dua to the causa(s) and manner stated. edicai 29a. Certifier (Check only one) 29c. Licansa number 29d. Daje signed (Month, Day, Year) 29b. Signature end tifle of certifiar D604431 n.D. corps es im D. JERRY 30. Nama end addrass of person who complated ceuse of death (Item 23a) (Type, Print) Hagustown 8 mon

Registrar **DHMH 16 Ray 6/95**

State

31. Data filad (Month, Day, Yaar)

1 3 1999

32. Ragisfrar's Signatura

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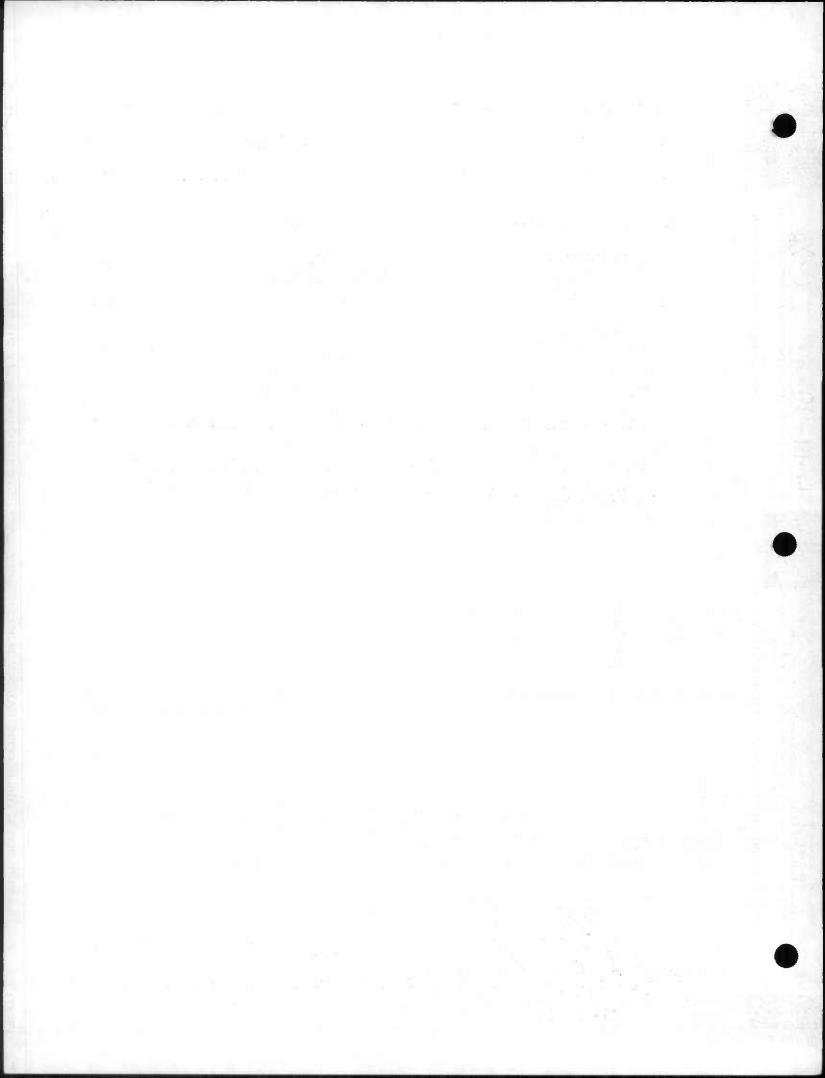
toning, Lela Joene

Aug. 11 1994 6155

State of Maryland / Department of Health and Mental Hygiene

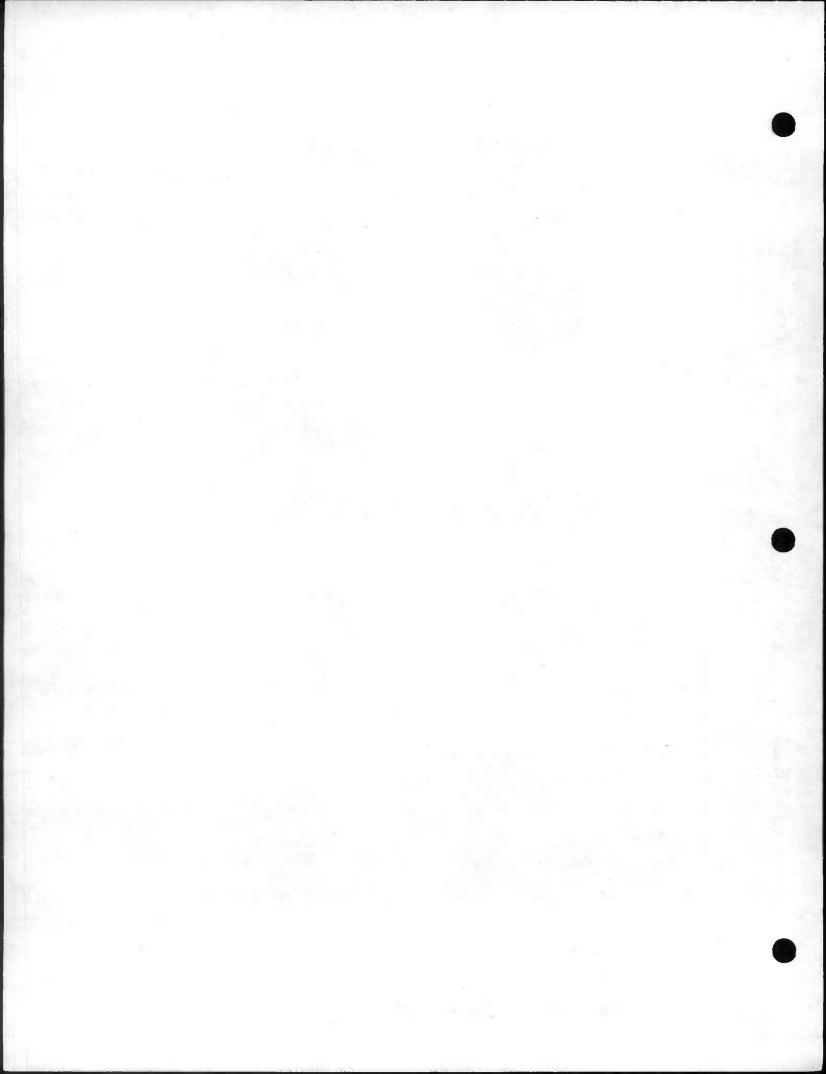
Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** RHODA APRIL ELIZABETH **ISEMINGER** 1999 7:50 P.M. /Medical 4a. Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HOMEWOOD RETIREMENT CENTER WILLIAMSPORT WASHINGTON If Undar 1 Yaar 8. Data of Birth (Month, Dey, Year) JULY 29, 1 If Undar 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign
Country) **Funeral** Months Deys 1□M 200 F Vm 214-09-7475 89 Director MARYLAND Usual Residence of Decedent 10s. State 10b. County 10c. Cify, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 1 No Director MARYLAND WASHINGTON WILLIAMSPORT 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? raumetic event, the Madical Examiner must be 16505 VIRGINIA AVENUE 21795 Funeral U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Rece - Amarican indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ò 1 ☐ Yes 2 ☒ No Specify: ģ Specify: 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) h and Mental h GEORGE R. KEFAUVER ARDELLA MAE McCREA 19s. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If flow 27 is m HAROLD. V. ISEMINGER./SON 10837 OAK VALLEY DRIVE, HAGERSTOWN, MD 21740 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Data 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) FUNKSTOWN CEMETERY 4/24/99 | FUNKSTOWN, MARYLAND Funeral Service Ucensee 22. Neme end Address of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Peh1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only ona ceusa on each line. Approximete Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse burial physician Physician/Medical the Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 Unknown ģ 8 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed has page 2 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) 1□ Yes 25(No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 28a. Date of Injury (Month, Dey Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: 5 Pending investigation 1 (Statural 2 Accident 1 Yes 2 No after deatl Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) ò Hospital 24 hours a To the Hospital within 24 hours To the Funeral † Certifying Physician: To the bast of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basts of examinetion and/or invastigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted. 29a. Certifier Medical (Check only one) 29b. Signature and titlerol who completed cause of deeth (Item 23e) (Type, Print) 32. Registra r's Signature State 1999 oaks Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. 11, 21, 0

		State of Ivialyia		rtificate of			Reg. No.	14040
Physician	Decedent's Name (First, Middle, Las					2. Dete of De Month	Dey	3. Tima of Death
/Medical	Ella		eth		Jones 4b. City, Town, or I		10, 1999	7:15 PM
Examiner	4a Fecility Name (If not institution, give						4c. County of	Death
5	Salisbury Center 5. Sociel Security Number 6. Se	: Genesis Eld	erCare	If Under 1 Yaar	Salisbury If Under 24 Hrs.	8. Date of Bir	Wicomic	
Funeral Director		□M 2XF 91	Yrs.	Months Days	Hours Min.	(Month, Da		B. Birthplace (State or Foreign Country) Maryland
2	Usual Residence of Decedent				1	TIVAGILLE	100 1507	-
a-f show iffed at	Maryland Wicomic		alisbur					10d. Inside City Limits 1 Yes 2 □ No
sher death with the Maryla or Rems 23a or 28a-f aho miner, mast be notified at r Funeral Director	310 Pryor Ave.			10f. Zip Code 21	804		10g. Citizen of Wh USA	et Country?
urs sher dea ar, or hems Examiner m by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Dacedent Evar in Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Detes:		Was Decedent of I If Yas, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Race Black, Specify:	American Indian, White, etc. White
Maryland 21215-UUZU 32 should be filed within 72 hours at h and Mental Hygiens. It is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by F	15. Decedent's Ed (Specify only highest grad	de com <i>pleted)</i>	16e. Dece (Give life.	dent's Usuel Occu kind of work done DO NOT use retire	pation during most of world)	king	16b. Kind of Busi	ness/Industry
Diameters of the second	Elemantery/Secondary (0-12)	College (1-4or 5+)	Hom	memaker			Dome	estic
land in the filed fental Hygi was other dc event, I o Be Co	17. Fathar's Name (First, Middle, Last) George E. Bell					na (First, Middla E. Brum	, Maiden Sumama, bley	
and should will be a should be	19a. fnformant's Name/Relationship (7	ype, Print)			end Number or Ru			
- FEE	Peggy A. White/	Daughter	509	S. Kaywo	od Dr., S	Salisbur	y, MD 218	304
altimore, mil. Pages 1 ar partment of Hea portrant: If Item y Injury or other	20e. Method of Disposition 130 Buriel 2 Cremation 3 4 Donetion 5 Other (Specify	Removal from State	cematary, crai	osition (Neme of metory or other pla Memorial Pa	1,	Dete 4/14/99	20c. Location - C	ity or Town, Stele
Dien in in in in in in in in in in in in in	21. Signatura of Funaral Service Licen-	1	22	2. Nama and Addre	ass of Facility			
D SSEES	* WK. Hall	In CFS.			Funeral H Hill Rd.,			Association 21804
	23a. Part1. Enter the disease, or composhock, or heart failure. List only of	lications that caused the del	ath. Do not an	tar tha mode of dyi	ng, such es cardiac	or respiratory a	rrast,	Approximate Intervel Between
Physician								Onset and Death
/Medical Examiner	Immediate Ceuse (Final disease or condition rasulting in death)	· Mour	mm					4 Portys
9			(or es a conse					
executed an and rial-transit	Samuel all all and all all all all all all all all all al	0.	(or as a consec) Ne Neg				
cate be executed physician and sthe burial-transit	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disaase or injury	Due to	(OI as a COIIse	querice or).				
icate be ephysician s the buria	Cause (Disaase or injury that initiated events rasulting in death) Last	c. Dua to	(or as a consec	juence of):				
	The same of the sa							
BOX of Both Certification attending attending I for use as		d						
the at	Pert ff. Other significant conditions co	entributing to deeth but not re	sulting In tha u	nderlying causa gi	ven in Part I.	23b. Did	tobacco use cont	ributa to the cause of death?
s that the state that the state by a detaction by Phy	Dove POINTA	Se	Ano	my		10	Yes 2 No	B □ Probably 4 □ Unknown
If RECORDS, P.O. BOX 58 / 50, The law requires that the death certificate be executed tale has been signed by the attending physician and page 2 should be detached for use as the burial-transit Completed by Physician/Medical Examil	ASCUD	6	lyso	MyRon	el .	24a. Was	en eutopsy ormed?	24b. Were autopsy findings available prior to completion of causa of deeth?
2 2 2 2	Onlater					10	Vas 2 No	1 Yas 2 No
lclen: The certificate rector, pa	25. Wes case referred to medical				26. Plece of Dea			1210 9210
nysicianis cer il direc	examiner? 1 Ves 20 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 DOA Ot	her /		dence 6 □Othar	(Specify)
ding Physical distributions of the control of the c	27. Manner of Death 1 Netural 5 Pending 2 Accident Invastigation	28a. Date of Injury (Month, Dey Year)	28b. Time o Injury	Wo	ry et irk? I Yes 2 □ No	28d. Describe	how injury occurre	d
To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director. Medical Certification: To Be (3 Suicide 6 Could not be determined		home, farm, str city)	reet, factory, office		28f. Location (City or To		or Rural Routa Number,
oepital hours a unerel t siy filled	29a. Certifier Certifying Phy	relcian: To the best of my kr	nowledge, death	h occurred at the ti	me, date and place	, end due to the	cause(s) end man	ner es steted.
the Hospi hin 24 hou the Funer npietely fil	one)	and manner steted.						
To the To the Com	29b. Signature and the of certifier			29c. Licen	se number		29d. Date signed	(Month, Dey, Year)
out	vuo			1	5781	5	411	179
1	30. Name and address of person who o	ompleted causa of death (Its	en 23a) (Typa,	Print)	Dan	2,5	shs m	2/99
State Registrar	31. Date filed (Month, Dey, Year) APR 1 3 199	32. Registrar's Sign		Soan	41			



AKA:

Baltimore, Maryland 21215-0020

4 - Homicida

Directo

Funeral

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Completed

Be

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentel Hyglene. Important: If item 27 is marked other than "naturel", or items 23e or 28s-f show any injury or other traumatic event, the Medical Examinet must be notified at once.

Physician /Medical

Examiner

	Plea	ase Type or							_		jible.	01.1		
		State	of Marylan		ertificat			יום וע		Reg. No.		1341		
1. Decedant's Nam	na (First, Midd	le, Last)							2. Data of Da	eeth		3. Tima of Dea		
Frank			amin	J	Johnso				April	Day 8,	1999	12:00 2		
4a Facility Name (If not institution	on, give street and no	umber)			4	b. City, Town	n, or Lo	ocation of Daat	h 4c. Coun	nty of Death	1		
Johr	n Hopki	ns Med	lical Co	enter			Balti							
5. Social Security N 220-16-	9815	6. Sax 12X(M 2□ F	7. Aga (In yrs. 74	last birthday Yrs.	Months	1 Year Days	If Undar 24 Hours	4 Hrs. Min.	8. Data of Bir (Month, Da		Cou	hplace (State or Foi untry) yland		
Usual Rasidance o 10a. State	10b. County	,	10c. Cit	ty, Town or L	ocation							10d. Insida City Lin		
Maryland	Somer	set	Upp	er Hil	.1							1 □ Yas 2 kg		
10e. Street end Nu					10f. Zip	Coda				10g. Citizen o	f What Co	untry?		
27849	Jim-mo	re Road			218	68				USA				
11. Marital Status		12. Was Dad	cedant Ever in U,	,S. 13	. Was Decer	dant of H	lispanic Origin	in? (Sp	pecify Yas or No			ricen Indian,		
1 Navar Marr		rried 1 X Yas If Yes, G	Armed Forces? 1 Yas 2 No If Yas, Giva Yaar or Datas:						Rican, atc.)	Spec	iack, White	a, atc. Lack		
(Spe		nt's Educetion est grade completed,)	16a. Dace (Giv	edant's Usue	el Occupi	eation during most o	of work	king	16b. Kind of	Businass/li	ndustry		
Elementery/Seco	ondary (0-12)	College	(1-4or 5+)		esman	16 160.00						Company		
17. Father's Name	(First, Middle,	Last)					18. Mothar's	s Nam	na (First, Middle	, Malden Sum	ame)			
Joseph	1		John	nson			Laura	а		Dorma	ın			
19a. Informant's N	lame/Relations	ship (Type, Print)		19b. Mai	ling Addrass	(Street	and Number	or Rur	ral Route Numb	per, City or Tou	vn, State, Z	(ip Code)		
20a. Mathod of Dis	sposition Cremetion 5 Other (S		n Stata	Place of Disponentery, creened on the Place of Disponentery, creened on the Place of Disponenter	position (Nan ematory or o amily 22. Nama an	me of other place Ceme	etery		Data	20c. Location Upper	n - City or T	Town, Stata , Maryland		
Ole Berti Same	AL ALI	Small cations that	caused the deal	Po not a					ston, Ma		21601	1 Approximete		
		r complications thet t only ona causa on	aach lina.	n. Donot a.	TREE THE THOU	e or ayı.,	g, such as oc	Sidiac	Of respiretory s	masi,	1	Intarval Batweer Onset and Death		
Immediata Causa diseasa or condition resulting in death)	ion	а. Мус	cardial	infar							1	1 nou		
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rasulting in daath)			Due to (u	or as a conse	quance on:						1			
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Part II. Other signi	ficant conditie	ons contributing to o	daath but not ras	uiting in tha	underlying c	ausa giv	an in Part I.			4		to the cause of de		
Renal	Insuffi	ciency							10	Yes 211 No) 3□Pr	robably 4 Unk		
									24a. Wes	s an eutopsy formed?	a	Wara autopsy findir availabla prior to completion of cause of death?		
									10	Yas 2 No	,	1 □ Yas 2 □ No		
25. Was case rafe	rrad to medica	af					26. Placa c	of Dea	ath (Check only	one)				
axaminar? 1 ☐ Yas 2∜☐] No	Hospital:	Minpatient 2□	ER/Outpatie	ent 3 DC	OA Oth	ner .		loma 5□ Ras		Othar (Spe	cifv)		
27. Manner of Deal	ith 5 ☐ Pandir	28a. Date	e of Injury onth, Day Year)	28b. Tima Injury		28c. Injun Wor				how injury occ		,		
3 Suicida	6 ☐ Could	not be	ce of Injury - At he					-	00/ 1	(Change and Mr.	m har or B	ural Route Number.		

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Certification: To Be Completed by Physician/Medical Examiner

within 24 hours efter deeth.

To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) Medical

State Registrar

29b. Signatura and title of certifiar romer.

6 Could not be determined

MO

28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

29c. Licensa number D 47804

1 CCertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and mannar es steled.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and mannar stated. 29d. Data signad (Month, Day, Year) 418/99

28f. Location (Street end Number or Rural Route Number, City or Town, State)

30. Name end eddress of person who complated ceusa of daath (Item 23a) (Type, Print)

9600 North Point Road Fort Howard, MD 21052 Andrew Mrowiec,

31. Date filed (Month, Day, Year) APR 1 4 1999

32. Registrar's Signatura

Spark

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Dete of Deeth Dey **Physician** 1999 JOHN RAYMOND KNOLL 1903 APRIL /Medical 4e Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** ATLANTIC GENERAL HOSPITAL BERLIN If Under 24 Hrs. WORCESTER 8. Date of Birth (Month, Dey, Year) 6. Sex 12. M 2□ F 5. Sociel Security Number 7. Age (in yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours Min Yrs. 579-34-3066 Usual Residence of Deceden Director 69 with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Modical Examiner must be notified as 1 Yes 2 No ND. WORCESTER OCEAN CITY Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 14 38TH STREET 21842 Funeral USA 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien. 11. Maritel Status Black, White, etc. 4/17/99 190 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2/8 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nema. Pages 1 and 2 should be filed within beganning of Health and Mental Hygiena. College (1-4or 5+) Elementery/Secondary (0-12) LAND PLANNER ENGINEERING 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) TO JOHN R. KNOLL ELSIE ROBERTSON 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) BARBARA B. KNOLL SPOUSE 14 38 TH STREET, OCEAN CITY, MD 21842 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò 4-19 SALISBURY CREMATORY SALISBURY, MD. 22. Name end Address of Fecility ULLRICH FUNERAL HOME BERLIN, Final the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical myocon SB Examiner Physician/Medical Examiner DULUMONIL attending physician and for use as the burial-transit certificate be asscuted Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or es e consequence of): use as t 23b. Did tobacco use contribute to the ceuse of death? Part II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. signed by the 1 Yes 2 No 3 Probably 4 Unknown Kaymond Knol g 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? Completed cartificate has 1 Yes 2 100 1 Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospital: 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) funerai 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? I Director: After the din by the funeral Certification: 5 Pending Investigation or Attending 1 Heturel 1 Yes 2 No death. 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by within 24 hours after of To the Funeral Direct completaly filled in by 4 ☐ Homicide 29a. Certifier 1 Certifying Phyeicien: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner es stated. edicai 2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Rosert Durker 9733 | Heal Thurs 2

State Registrar 31. Date filed (Month, Dey, Year) APR 1 9 32. Registrer's Signeture

DHMH 16 Rev 6/95

3066

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death 19^{ey} April **Physician** 1999 Ormond Francis Kirwan 6:15 PM /Medical 4a. Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Dorchester General Hospital Cambridge Dorchester 6. Sex 1 🛣 M 2 🗆 F If Undar 1 Yaar If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Deys Hours 214-07-7743 Yrs. 92 Maryland Usual Rasidance of Dacadeni 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYas 2□No Maryland Dorchester Director Cambridge 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 715 Peachblossom Avenue 21613 US Funeral 12. Was Dacedant Ever in U,S. Armed Forcas? 1 □ Yas À XNo If Yas, Giva Year or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - Amarican Indien, Black, Whita, atc. 1 ☐ Naver Married XX Married 1 ☐ Yas XX No White þ Specify 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Dacedent's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plant Foreman Manufacturing 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Sumeme) Samuel Kirwan Louisa Clark 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Agnes A. Kirwan Wife 715 Peachblossom Avenue Cambridge, Maryland 21613 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Deuriai 2 Crametion 3 Ramoval from Stata 4 Donation 5 Other (Specify) Dorchester Memorial Park 4/22/99 Cambridge, Maryland 21. Signature & Funaral Sarvice Dicensee 22. Nama and Addrass of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a. Per I Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, show or heart tailure. List only one cause on each line. Approximata Intarval Batween Immediata Causa (Finai diseasa or condition rasulting in deeth) - upercarbia will by Dua to (or as a consequence of): neumonia week Sequantially list conditions, if any, laeding to immadiete ceusa. Entar Underlying Causa (Diseasa or injury thet initiated avants rasulting in death) Lest Dua to (or es a consaquance of): Chronic Dulmonary Physician/Medical Due to (er as a consaquance of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown þ 24b. Wara autopsy tindings eveilable prior to complation of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 25. Was casa ratarrad to medicai Be 28. Place of Daath (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 mpatiant 2 ER/Outpetient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Daath 28b. Time of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: Naturel 2 Accidant 5 Panding investigation 1 Yes 2 No NIA 6 Could not ba detamined 3 ☐ Suicida 28e. Placa of Injury - At home, farm, streat, tactory, office building, atc. (Specify) 28f. Location (Streat end Number or Rural Routa Number, City or Town, State) 4 Homicida NIA 1 Sertifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) end menner es stated.
2 Madical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred et the time, data and place, and due to the causa(s) and menner stated. 29a. Cartifiar Medicai (Check only 29c. Licansa number 29b. Signatura and titla of certifian 29d. Date signed (Month, Dey, Yeer)

A11284

400 MARYLAND AVE

32. Registrer's Signatura

20.99

CAMBRIDGE, MD 21613

Division of Vital Records, P.O. Box 68760, attending physician signed by the at d be deteched for peeu hes To the Hospital or Attending Physician: The within 24 hours affed death.

With Funeral Director: After this certificate is completely filled in by the funeral director, page completely filled in by the funeral director, page.

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygenes. Attention of terms 23s or 28s-f show important: It flems 7 is marked other than "natural", or items 23s or 28s-f show sny injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical

Examiner

end

be executed

the burial-transit

88

Baltimore, Maryland 21215-00200

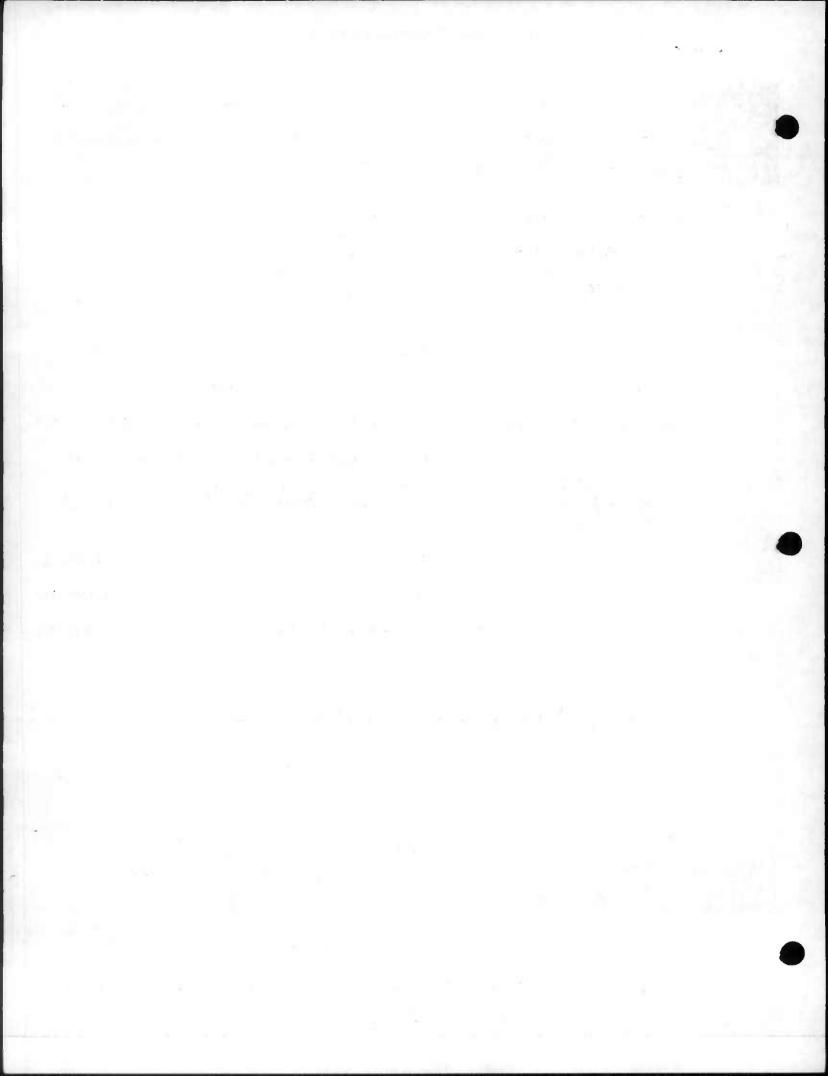
State Registrar 30. Nama and address of parson who complated causa of death (Item 23a) (Type, Print)

WILKE MD

APR 2 1 1999

31. Data filed (Month, Day, Yaar)

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

APRIL 23, 1999

OAKLAND, MD 21550

						Cer	tificate o	f Death		Reg. No.	1 10	
			ame (First, Middle,	Last)					2. Dete of D		Voor	Time of Deeth
П	Physician /Medical	TERRY	ELDON	KNOTTS					APRIL	21, Day 199	9 ^{Yeer} 1	0:38 AM
	Examiner	4e Facility Neme	e (If not institution, g	giva straat and nu	ım <i>ber)</i>			4b. City, Town,	or Location of Dea	th 4c. Count	y of Deeth	
4		GARRE'	TT COUNTY	MEMORIA	AL HOSPI	TAL		OAKLAN	D	GA	RRETT	
	Funeral Director	5. Sociel Security 214-56		Sex 1Ã0 M 2□ F	7. Age (In yrs. 49	last birthday) Yrs.	If Under 1 Yas Months Day		lin. (Month, D	irth 19, Year) 1950	9. Birthplece Country) I CANAL	(State of Foreig ANAMA ZONE
	p ,	Usuel Residence	a of Decedent 10b. County		100 0	ty, Town or Loc	nation				10d I	nside City Limits
	ahow		GARR	FTT	100. 01	OAKLA						☐ Yas 210 No
	Ne M	110				V121232				10= Ohinan of		
	Vith it	10e. Street end I		D			10f. Zip Code	550		USA	Whet Country?	
	ath v	3490 H	UTTON ROA		a deat Francis I	10 10 1			/Consider Van on N		ce - Amarican In	dian
020	be filed within 72 hours efter death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Exerting must be notified at 88e Completed by Funeral Director	3 ☐ Widowe	s arried 2⊠ Married d 4 □ Divorcad	Armed F	2⊠ No iva		Yes, specify Co		(Specify Yas or Nuerto Rican, etc.)	Speci	ock, White, etc.	
9-0	2 ho	(6)	15. Decedent's pecify only highest			16e. Deced	ent's Usual Occ	upation	working	16b. Kind of E	Business/Industr	4
21215-0020	should be filed within 72 hos and Mental Hygiena. • marked other than "natura umatic event, the Medical E. To Be Completed	Elementary/Set	econdary (0-12)		(1-4or 5+)		SELOR	e duning most of red)	working	HEAL	TH CARE	
nd	d oth	17. Fathar's Nen	ne (First, Middle, La						Name (First, Middle			
yla	Meni Meni Meni Meni Meni Meni Meni Meni	DELBE	RT KIRKW	OOD KNO	OTTS			DOTTY		BOLY		
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	1 end Heelth em 27		D. KNOTT	S - WIFE			HUTTON	KUAD	OAKLAND			
Baltimore,	Pege nnt: If Iry or		Disposition 2 Cremetion 3 in 5 Other (Spe		State	cemetery, crem	sition (Name of hatory or other p CEMETERY		Date 4/24/99		- City or Town, S	
Balt	permit. Departrimporta	21. Signature of	Ameral Service Lic	eus!	M001		Name end Add		P.O OME - OAI	D. BOX 2 KLAND, M		
	Physician /Medical	23a. Part1. Ente shock, or h Immediate Ceus disaese or cond	er the disease, or coneart failure. List on see (Fine)	ly one cause on	caused the dee				dlac or respiretory	errest,	Inte Ons	oroximete ervel Between sat and Daath ediate
L	Examiner	resulting in deat	h)	eath	Due to (orasaconsequerotic h		isease			yea	rs
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x 68	eath certificate be axecuted attending physician end for use es the burial-transit clan/Medical Examir	resulting in deet	n) cost								1	
Boy	tandi or use			d								
	0 0 0	Pert II. Other sig	nificent conditions	contributing to c	leath but not res	sulting in the un	derlying cause	given in Part I.	23b. Die	d tobecco use c	ontribute to the	cause of deeth
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Records,	been sign should be								24a. Wa	s an autopsy formed?	evelleb	utopsy findings le prior to ition of causa
Re	has be 2										17232	<u>-</u>
a	certificate har rector, page									Yes 2 No	1 ☐ Ye	s 2 No
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Division	After funa	1 X Naturel 2 Acciden	5 Pending investigat	ion	of Injury oth, Day Yaar)	Injury	28c. Ir V M 1	Vork? ☐ Yes 2 ☐ No				
Divis	al or Attendes setter death in Director:ad in by the Certifical	3 Suicide 4 Homicid	6 Could no determine	28e. Plac build	a of Injury - At h ling, etc. <i>(Speci</i>	ome, farm, stre	eet, fectory, office	×8		(Street and Num own, Stete)	ber or Rural Ro	nte Number,
	Hospi 24 hou Funer stely fill		1 ☐ Certifying 2 ☐ Medical Ex	aminer: On the t	e best of my kno pasis of examine nnar stated.	owledge, death etion end/or inv	occurred at the estigation, in m	time, date and pl y oplnion, death o	ace, end due to the	e ceuse(s) and n a, date end place	nanner as steted , and due to the	cause(s)
	within 2 to the comple		and title of certifier	1			29c. Lice	ense number		29d. Date sign	ed (Month, Day,	Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THOMAS G. JOHNSON, M.D. 311 N. FOURTH ST. 31. Dete filed (Month, Dey, Yaer)

32, Registrar's Signatura

books

D15333



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Lest) Month Apri **Physician** 2248 Virgil Charles Edwin Kelbaugh /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deat Examiner Hagerstown Washington washington County Hospital | H Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Sept. 28, 1939 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthplece (Stete or Foreign **Funeral** 1 M 2□ F Months Maryland 212-38-9560 59 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County rai', or items 23a or 28a-f show Exercises count be contribed at 1 Yes 2 No Director Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21742 U.S.A. 11301 Youngtoun Dr. Apt. 1404 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 □ Never Married 2 □ Married natural, or 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Wedical 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiena. marked other than Elementery/Secondery (0-12) Cotlege (1-4or 5+) Security Guard 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Charles Edwin Kelbaugh Margaret Montgomery 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Pnint) 7 Oaktree Ln. #C Williamsport, Md. 21795 of Haaith Debbie M. Pryor (Daughter) 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removal Smithsburg Cemetery April 23, 1999 Smithsburg, Md. □ Other (Specify) 22. Name and Address of Fecility Signature of Funeral Service Lisenser 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical anean Anting The Examiner Due to (or es e consequence of) Examiner Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in death) Last Due to (or es e consequence of): physician as s the burial-Physiclan/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the causa of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Phenmaria Dicht Millita þ 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No 10 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of Injury 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred Certification: 28c. Injury et Work? 1 ONaturel 1 Yes 2 No

Hospital

Kelbaugh, Virgi

Bud Director 6 Et hours a

the Maryland

Pages 1 and 2 should be filed within 72 hours after death

and Mental

2 signed by certificate ř

Registrar

edical

5 Pending investigation 2 Accident 3 ☐ Suicide

6 Could not be

28e. Place of injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner stated.

Hagerstown

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

tout mo

29c. License number 18015

29d. Date signed (Month, Dev. Year) APRIL 22, 1999

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Dr. Datta 31. Dete filed (Month, Day, Year)

APR 2 6 1999

29b. Signeture end title of certifier

4 Homicide

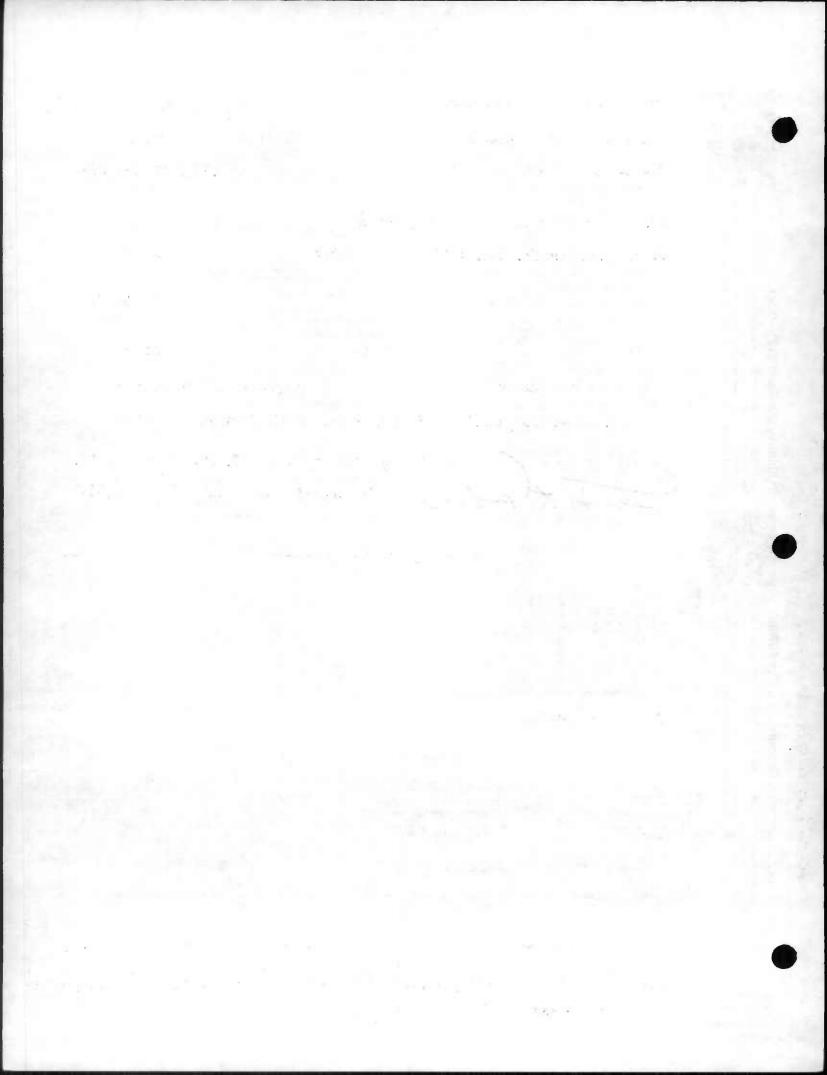
(Check only one)

29a. Certifier

32. Registrer's Signeture

DHMH 16 Rev 6/95

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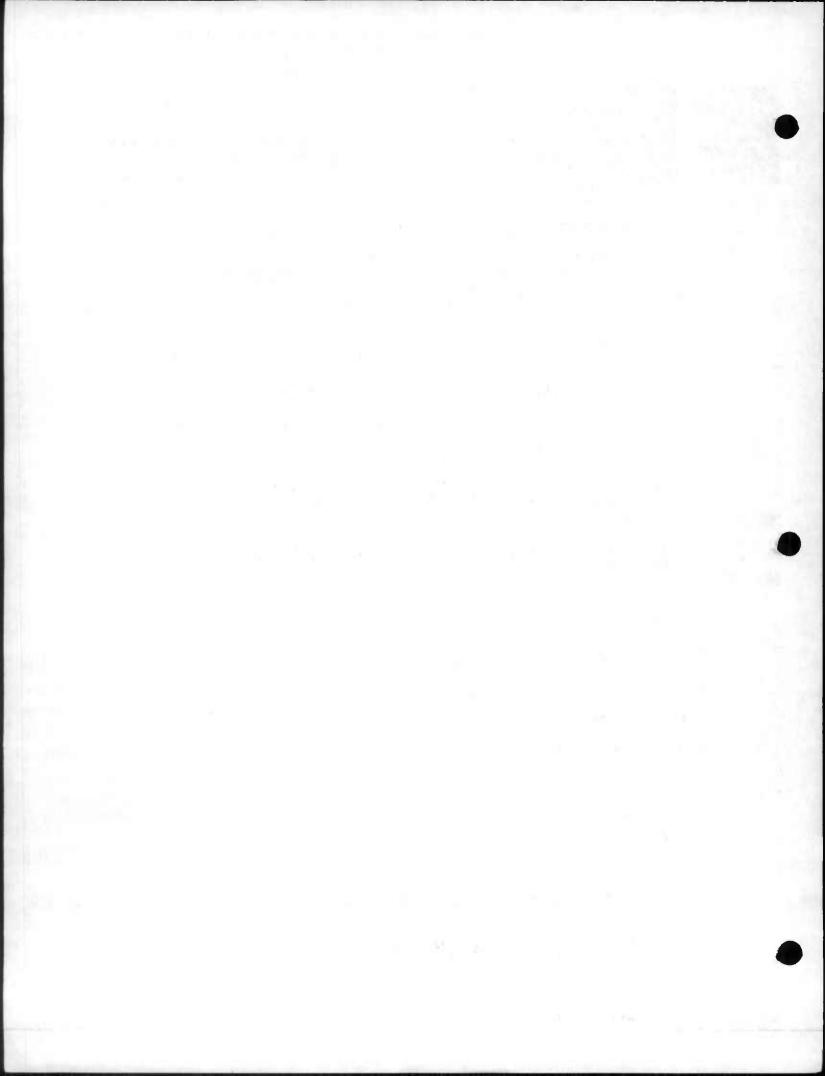


State of Maryland / Department of Health and Mental Hygiene 9 4346

				(Certificate of	Death	Reg.	No.			
		1. Decedent's Nama (First, Middla, Las	1)		U- 100 -		2. Data of Deeth		3. Time of Daath		
Physic /Medi		Omer Thomas	Kaylor,	Jr.			April 19,		0200		
Exami		4e. Facility Nama (If not institution, giva				4b. City, Town, or I		4c. County of I			
		Mercy Hospital Ce	enter			Baltimore		Baltimo	re		
Funeral Director		5. Social Security Number 6. Sa 217 16 2917		(In yrs. last birth	day) If Under 1 Year Months Days	r If Under 24 Hrs.	8. Data of Birth (Month, Day, Ye July 14, 19	9. 123 Ma	Birthplace (Steta or Foraigi Country) ryland		
show	2	Usual Residence of Dacedent 10a. State 10b. County		10d. Insida City Limits							
or 28a-f	Director	Maryland Washingt 10e. Street and Number	on	Hagerst	OWN 10f. Zip Coda		10g.	Citizan of Wha	1 X Yas 2 No t Country?		
th wi		940 The Terrace			21742		U	SA			
772 hours after death with the Maryland "neturel", or items 23s or 28s-f show saftest Exercities to set the notified at	by Funeral	11. Marital Status 1 □ Naver Memied 2 ☑ Marrled 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forcas? 1 ⊈Yes 2 □ N If Yas, Giva Yaar or Dates: ↓	0	13. Wes Dacedant of If Yas, specify Cu 1 ☐ Yas 2 ☑ No	ban, Maxicen, Puart	pecify Yas or No- p Ricen, atc.)		Amaricen Indian, Whita, etc. White		
in 72 ho	ted	15. Decedant's Edu	icetion	16a. D	ecedant's Usual Occu	pation	166	. Kind of Busin			
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htal Hygle of other svent,		17. Father's Nema (First, Middle, Last)	10		iccorney	18. Mothar's Nan	na (First, Middle, Maid				
T T T T W	To Be	Omer Thomas Kayl	or, Sr.			Mabel H	Elizabeth	Slagen			
s 1 and 2 should b f Haalth and Mente tam 27 is merked other traumetic s	1	19a. Informant's Name/Ralationship (7)		19b. l	Mailing Addrass (Stree						
and 2 sho alth and 27 is me		Jean J. Kaylor	wife	1 .	The Terra						
other tr		20a. Mathod of Disposition	WITE	20b. Place of I	Disposition (Nama of				or Town, Stata		
Pagas nant of I int: If Ite		1 ⊠ Burial 2 ☐ Cramation 3 ☐ F		cemetery	cramatory or other pl						
than		4 Donation 5 Other (Specify)		kest h	aven Cemet		/23/99 Ha	igersto	vn, Maryland		
permit. Paga: Department or Important: If I any injury or		21. Signatura of Funaral Sarvice Licens	Mmm	ch	Gerald N. Funeral H	Minnich		N. Potor	mac St. Md. 21740		
		23a. Pert1. Entar tha disaasa, or compl shock, or haart failura. List only o	ications that ceusad	tha daath. Do no					Approximata		
aath centificata be axecuted attanding physician and for use as tha burial-transit	edicai Examiner	Saquantially list conditions, if any, leading to immediata ceuse. Enter Undarlying Cause (Disaase or injury that initiated evants	c	Oua to (or as a co		3			E.		
th certifica anding ph r use as th	3	rasulting In death) Last	d	,							
tha daath y tha atte	sici	Part II. Other eignificant conditions con	ntributing to death bu	t not rasulting in t	ha undarlying causa g	ivan In Pert I.	23b. Did tobac	cco uee contril	outa to the cause of death		
that ad b	by Physician	Mitral value pro	plapse				1 Yes	2□No 3[Probably 4 Unknow		
aw requir ts been s 2 should	Completed	Mitral value pro	plasm				24a. Wes an a performed		4b. Wara autopsy findings evailable prior to completion of cause of death?		
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ician: The cartificata rector, pag	Bec	25. Was casa raferred to medical				26. Pleca of Dea	th (Check only one)	,			
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Attending Physic daath. sctor: Aftar this by tha funaral d		27. Manner of Death 1 Natural 5 Pending 2 Accidant invastigation	28a. Data of Injun (Month, Day	28b. Tir	ne of 28c. Injury			a 5 ☐ Rasidence 6 ☐ Othar (Specify) Bd. Dascribe how injury occurred			
s aftar daat il Diractor: ed in by tha	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At homa, farn (Specify)	, street, factory, office	,	28f. Location (Stree City or Town, S.		r Rural Routa Number,		
to the trospital or Attending Fro within 24 hours after death. To the Funeral Director. After the completely filled in by the funeral	edical	29a. Certifiar (Check only one) 1 Certifying Physical Certifying Physical Examiles	sician: To the best of nar: On the basis of and mannar stat	axamination and/	daath occurred at tha tor Invastigation, in my	ime, date and place opinion, daath occur	and dua to the cause rred at tha tima, data	e(s) and manne and place, and	er as stated. dua to the causa(s)		
Vithii To the	M	29b. Signature and title of certifier	man 1	5-Ph.D.	29c. Licen	sa number	29d.	Data signed (N	lonth, Dey, Year)		
		30. Nama d addrass of person who co	omplated ceusa of da	eth (itam 23a) (T	/pe, Print)						
Sta	40	31. Date filed (Month, Day, Year)	32. Pagistra	's Signature	, ,						

Registrar

APR 2 1 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

							(Certificate	e of	Death			Reg. No.			
				1. Decedent's Neme (First, Middle,	Last)							2. Dete of De	eath			Time of Deeth
		ysicia	_	Charles Albert	KEPLINGE	R						Month April	Dey 17.1	Yeer .999		25 p.m.
		ledica amine	_	4e. Fecility Neme (If not Institution,	give street end nur	nber)				4b. City, To	wn, or Lo	ocation of Deel		ounty of Dec	-	2.) p.m.
	,	annine	1	Homewood Retire	ment Cen	ter				W	4114	amspor		Washi		n
	Fun	oral				7. Age (In yrs	. lest birth	hday) if Under	1 Yea		_					
	Fun Dire			214-09-8009 Usuel Residence of Decedent	18∆ M 2□ F	84		rs. Months	Deys	s Hours	Min.	8. Date of Bi (Month, Di April	1,191	.5	ountry) Mary	Stete or Foreign land
	and		1	10e. State 10b. County		10c. C	ity, Town	or Location							10d. In	side City Limits
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	the A	in the	Š	10e. Street end Number	ington				-				40 000			- 111 (1-11)
9	of Z.1.Z.1.3-UOZO (illed within 72 hours efter death with the Maryland Hygiene. ther than "natural", or items 23a or 28s-f show	ustbe	by Funeral Director	16505 Virginia	Avenue			10f. Zip	Code	21795				n of Whet C	ountry?	
10	dea m	9	l le	11. Maritel Stetus	12. Wes Dece Armed Fo	dent Ever in U	U,S.	13. Wes Deced If Yes, spec	ent of	Hispenic Orl	lgin? (Sp	ecify Yes or No	0- 14.	Race - Am		lien,
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117	2 ho	Cal	9	15. Decedent's	Education		16a. [Decedent's Usue	I Occi	pation			16b. Kind	of Business	/Industry	
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0	Md2	tra		Larry C. Kepling				942 Spie					-			•
1 9	os 1 end 20 Health Hem 27 I	the	ŀ	20e. Method of Disposition	,01, 0011	20b.		Disposition (Nem			, ,,,	Dete		tion - City or		
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0 5	ing in	9	5	1 Naturel 5 ☐ Pending		of Injury h, Dey Year)	28b. Tir Inj	jury		ork?		28d. Describe	now injury o	ccurred		
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			3	30. Name ond andress of sersen wh	o fompleted cause	e of deeth (Ite	m 23e) (T	Type, Print)		1	11		1	1		
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State of Maryland / Department of Health and Mental Hygiene

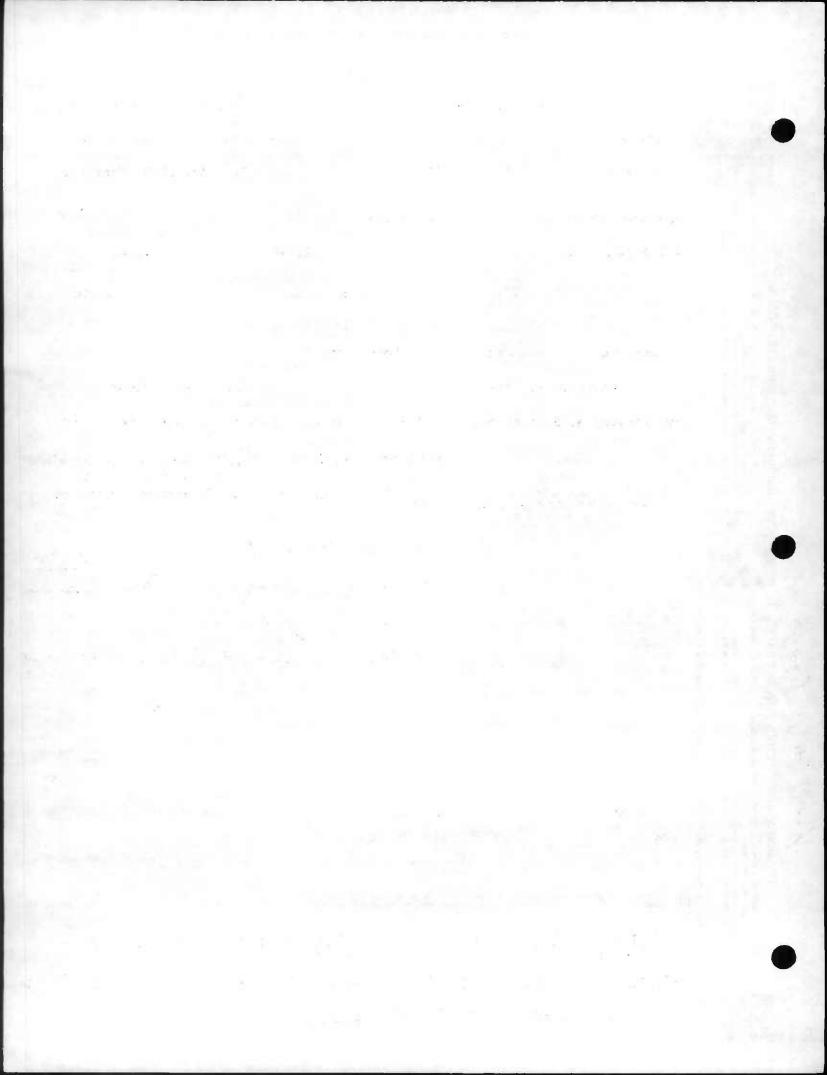
Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 08:16 Gladys Georgia KEMP 6 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington County Hospital Hagerstown Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Nov • 15, 1920 Birthplace (Stete or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1□ M 25 F Yrs. 220-18-0604 78 Maryland Director Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or items 23e or 28a-f show traumatic event, the Mod cal Examiner must be notified 14 Yes 2 No Maryland Directo Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 437 Salem Avenue 21740 U.S.A. Funeral death 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Peges 1 and 2 should be filed within 72 hours after Department of Haalth end Mental Hygiena. Important: If Item 27 Ia merkad other then "naturel", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: white þ 3 [™] Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown homemaker her own 18. Mother's Name (First, Middla, Maidan Sumeme) 17. Father's Name (First, Middle, Last) Columbus R. Toms Sally Leona Plume 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 19a. Informant's Nama/Ralationship (Type, Print) Mr. Gregory A. Plotner/son 437 Salem Avenue, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or Apr. 20,1999 Rest Haven Mausoleum 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Servica Licansee Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 cot 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** Cardiac Arrest /Medical Immediata Causa (Final diseasa or condition rasulting in daath) Few hum Examiner ardiorespiratory Failure Examiner the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Diseasa or Injury that Initiated events resulting in death) Last Physician/Medical 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. the 1 Yes 2 No 3 Probably 4 Unknown signed by by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 24 hours efter death.

Funeral Director: After this certificate has or Attending Physicien: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of tnjury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar es stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifier edical completely (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 4.16.99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHA 376 MILL ST. HAGERSTOWN MOZITE MO 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature APR 1 9 1999

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** KNUPP LUCILLE YSAA 07:50 4b. City, Town, or Location of Death /Medical 4a Fecility Name (If not institution, give street and number) 4c. County of Death **Examiner** HAGERSTOWN WASHINGTON COUNTY HOSPITAL WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** 1□ M 2KF MAY 16 19 14 WAYNESBORD, PA 173 03 3525 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours efter death with the Meryland Department of Heelth and Mental Hygiene.
Department: If term 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Exammer must be notified a 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits PA WAYNESBORO FRANKLIN 1 Yes 2 □ No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17268 USA. 66 MOUNT VERNON TERRACE Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Americen Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE à 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AIDE NURSE'S HOSPITAL 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) MARY Lowe AND REW REID 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) YORK PA KNUPP 401 WATERS RD 1 HOMAS 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Seurial 2 Cremation 3 Memoval from State TREENHILL CEMETERY APRIT WAYNESBORD PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GROVE FUNERAL HOME 50 SBROAD ST LIAYNES BORD PA 17268 Dowerrow ames 23a Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, and or heart failure. List only one cause on each line. Physician Massin Garlos /Medical Immediate Ceuse (Finel disease or condition resulting in death) **Examiner** Examiner andras a ettending physician and for use as the burial-trensit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of) signed by the etter Part II. Other significant conditions contributing to death but pot resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? Pulmonery 1 Yes 2 No 3 Probably 4 Unknown Diseas þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Was en autopsy certificate has t lirector, page 2 s 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was cese referred to medicel examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 D Natural 5 Pending 1 Yes 2 No efter death. Director: Af investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Certifier To the Hosp within 24 ho To the Fune completely f 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown Medical Campus Road Khan 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State **APR 16** Registrar

DHMH 16 Rev 6/95

Mary Louise Knupp

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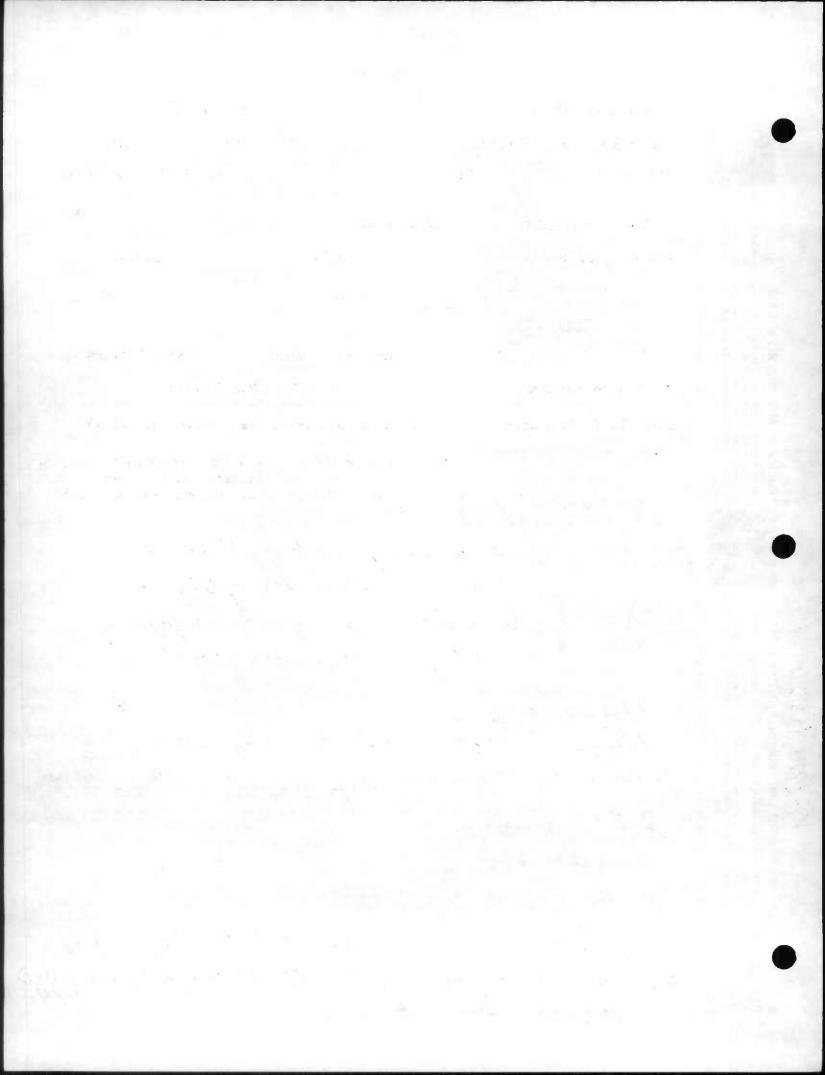
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** tori Robert Harry KEEDY /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Name (If not institution, give street and number) Examiner Hagerstown Min. National Managerstown Min. National Managerstown Min. National Managerstown Mana Washington County Hospital Washington Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days 1MM 2□ F Months 73 30 1925 Director 220-16-2346 Dec. Maryland Usuel Residence of Decedent the Maryland 10d Inside City Limits 10a State 10b. County 10c. City. Town or Location r 28a-f show 1 No Yes 2 No Directo Washington Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 7 is marked other than "natural", or items 23a or trsumatic event, the Medical Examinar must be 103 Stouffer Avenue 21740 U.S.A. Funeral 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☑Yes 2 ☑ No
If Yes, Give
Year or Dates: 1943–44 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Hygiane. 8 Auto Dealership Automotive Painter permit. Pagas 1 and 2 should be file Department of Health and Mantal Hy Important: if Nem 27 is marked othe eny injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Charles Jessup Keedy Ella Mae Bennett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Betty L. Keedy - Wife 103 Stouffer Avenue Hagerstown, Md. 21740 Baltimore, 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/16/99 Rest Haven Cemetery Hagerstown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the shock, or heart feilure. List only one ceuse on each line. enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lesf physician s tha burial Physician/Medical 98 for usa 23b. Did tobecco use contribute to the ceuse of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown à 8 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 has 1 Ves 2006 diractor, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 00 No 9 1 Yes 1 Sepatient 2 ER/Outpatient 3 DOA this funarai 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Menger of Death 28b. Time of Aftar Division Attending Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hour. the Funeral Direction by à 4 Homicide ò Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier edicai To the Hosp within 24 ho To the Fune complataly fi (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) TANVIR MI 31. Date filed (Month, Day, Year) 32. Registrar's Signeture

State Registrar

APR 1 5 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death

Physician /Medical **Examiner**

4e. Fecility Neme (If not institution, give street and number) Dorchester General Hospital 5. Sociel Security Number

4b. City, Town, or Location of Deeth Cambridge

April 19, Dey 1999 Yeer 12:55 PM 4c. County of Deeth

Funerai Director

288-1

items 23a or

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Hyglene.

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked or any Injury or other traumatic eve

the Medical Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

by

Be Completed

10b. County

Months Yrs. 10c. City. Town or Location

If Under 1 Year

10f. Zip Code

Deys

If Under 24 Hrs. 8. Dete of Birth Feb 3, 1920

9. Birthplece (State or Foreign Pennsylvania

Usuel Residence of Decedent 10a State

220-07-0388

Maryland Dorchester Cambridge

7. Age (In yrs. last birthday)

10d. Inside City Limits 1 X Wes 2 No

10e. Street and Number

215 West End Avenue

21613 Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

Hours

US

Dorchester

11 Marital Status

1 Never Married 2 Married XX Widowed 4 □ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes Ž(XNo

79

1 ☐ Yes XXINo Specify:

14. Race - American Indian, Black, White, etc. White Specify:

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12) College (1-4or 5+)

Marie Matthews Lilliendahl

1 M 2 XF

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

10g. Citizen of What Country?

10 17. Fether's Name (First, Middle, Last)

Henry Pfau, Sr.

Seamstress Shirt Factory 18. Mother's Name (First, Middle, Maiden Surname)

Catherine Chessman

2 19a. Informent's Name/Reletionship (Type, Print)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 West End Avenue Cambridge, Maryland 21613

Edward W. Matthews Grandson

20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete

20e. Method of Disposition

1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

Jugar

East New Market Cemetery 4/22/99 E. New Market, Maryland

21. Signatur Funerel Service Licensee

22. Name end Address of Fecility
Thomas Funeral Home, P.A.

700 Locust Street Cambridge, Maryland 21613 Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Intervel Between

Physician /Medicai Examiner

the buriel-transit

for use as

page 2 should Completed

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director.

þ

Be

2

Certification:

Medicai

The lew requiras that the death certificate be executed

Box 68760.

P.O.

of Vital Records,

Division

Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury thet initiated events resulting in deeth) Lest

Immediete Ceuse (Final diseese or condition resulting in death)

Pert If. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 3☑ Probably 4☐ Unknown

24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy performed?

1 Tes

26. Plece of Deeth (Check only one)

completion of ceuse of death? 1 ☐ Yes 2 No

Onset and Deeth

25. Wes cese referred to medical examiner? 1 Yes 2 No

27. Menner of Deeth

1 Natural

2 ☐ Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

1/2 Inpatient 2 ER/Outpetient 3 DOA Date of Injury (Month, Day Year) 28b. Time of

28c. Injury et Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

2/1 No

29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifier

w

D50987

29c. License number

29d. Dete signed (Month, Day, Year)

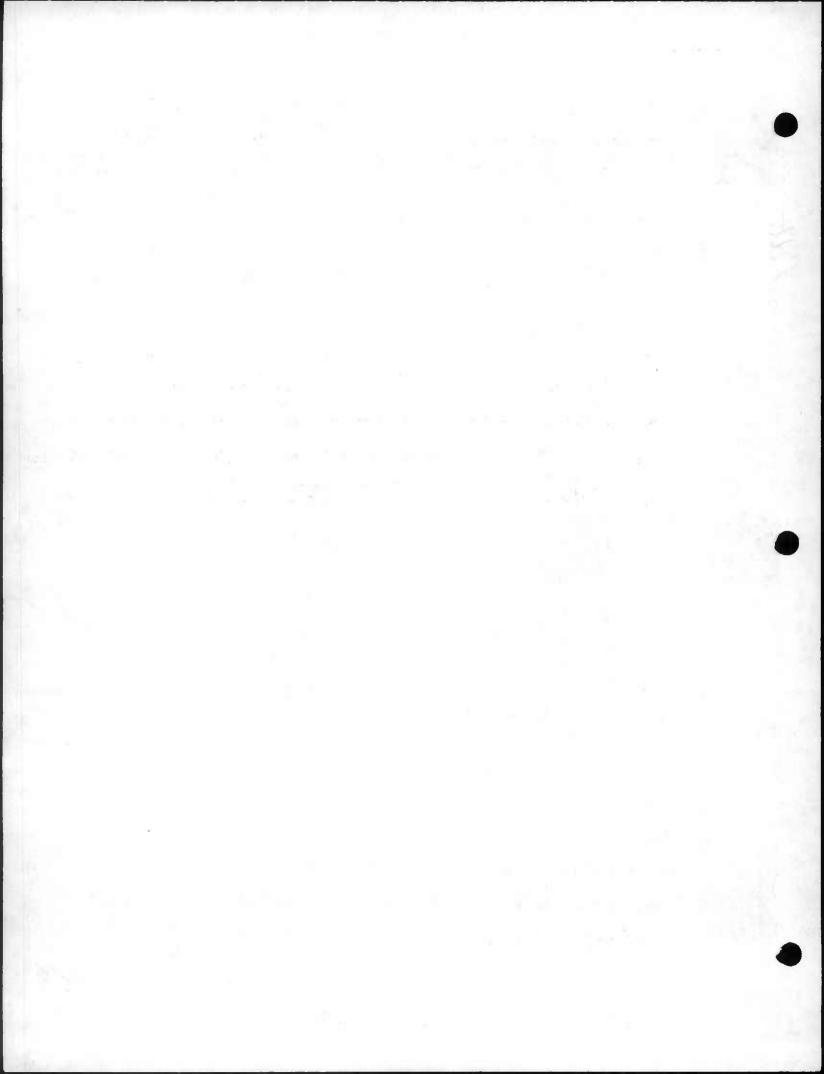
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

sweet Cambridge mo 21613

State Registrar 31. Date filed (Month, Day, Year)

Numaz 105)

Aurora



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Month A 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 4b. City, Town, or Location of Death Mildred Inena Lewis 10 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Washington County Hospital Hagerstown Washington County If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Months 1 ☐ M 2 🛣 F 84 Yrs. 214-28-5248 Sept. 13, 1914 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Co. 1X Yes 2 □ No Boonsboro 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8507 Mapleville Road 21713 USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerlo Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Force s? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 14. Raca - American Indien, 11. Meritel Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married specify: White 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Private Residence 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Roy Smith Nellie Willard 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Ada Juette Keedy/Daughter 1742-2 Edgewood Circle, Hagerstown, Maryland 21740 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Surial 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) Grossnickle Brethren Cem. Apr. 13 Myersville, Maryland 22. Name end Address of Fecility Douglas A. Fiery Funeral Home 21. Signeture of Funerel Servica Licansee 23a. lant. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, hook, or heart failure. List only one cause on each line. 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel STROKE Due to (or es e consequenca of): disease or condition resulting in deeth) ATHROSCLEROSIS Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): 23b. Did tobacco use contributs to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Hypertension Hyperlipidemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy 2 No 1□ Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 2 □ ER/Outpetient 3 □ DOA 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No

physician and the burief-transit requires that the deeth cartificete be axecuted Division of Vital Records, P.O. Box 68760 ettending pl signed by the e cartificata hes i or Attending Physician: this funeral daath. ofter daath Director: A d in by the f To the Hospital or A within 24 hours efter To the Funeral Directomplately filled in by

Examiner Physician/Medical þ Completed Be 2 Certification:

Physician /Medical

Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

permit. Pegas 1 and 2 should be filed within 72 hours after deeth with the Meryland Department of Heelth and Mantel Hygiene. Important: If them 27 is marked other than "natural", or items 23s or 23s-f show plucy or other treumstic avent, he Medical Examination not be not above.

Baltimore, Maryland 21215-0020

1□ Yes 2 No 27. Manner of Deeth Naturel 2 Accident

3 Suicide

4 Homicide

investigation 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

Tertifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end menner steted. 29a. Certifier (Check only one) 29b. Signature end title of certifier

29c. License number

29d. Date signed (Month, Day, Year) April 10, 1999

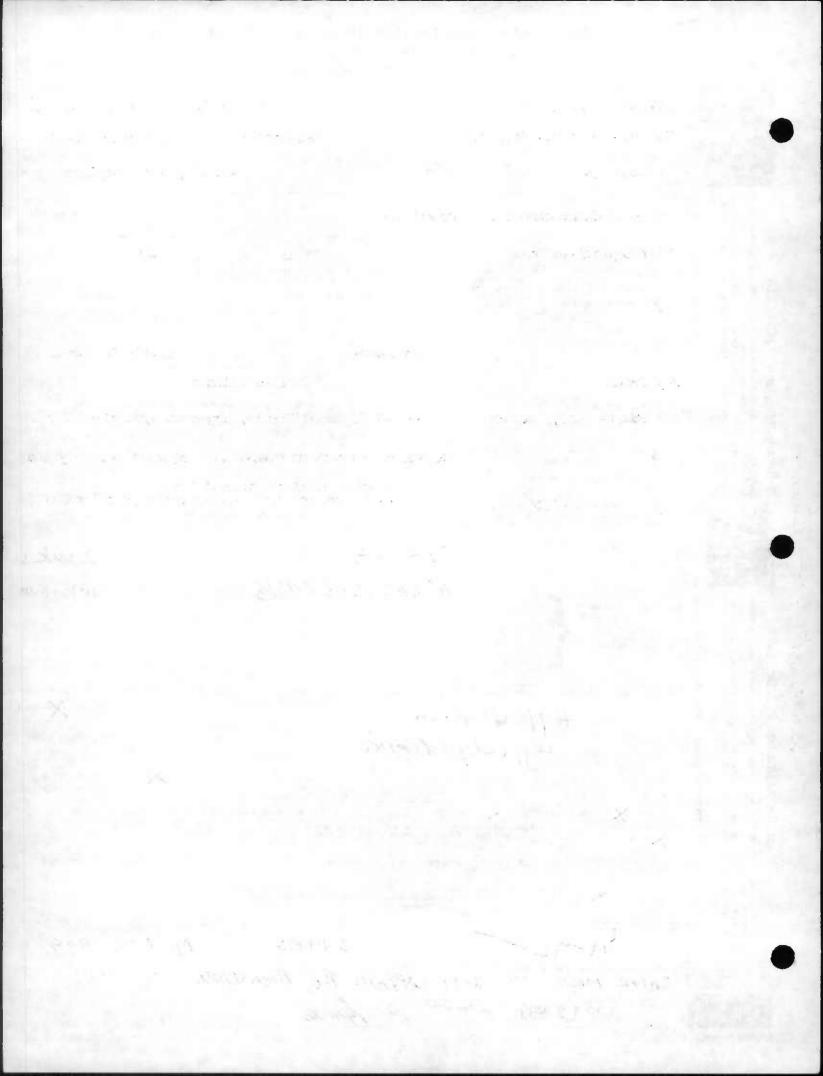
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

2484 Marik Ma 20311 Laffans Ro RoomsBorro Mp 2/7/3

State Registrar

Medical

31. Dete filed (Month, Dey, Yeer) APR 1 3 1999 32. Registrer's Signeture



DIVISION OF VITAL RECORDS, P.O. BOX 68760

1

Margare TEm: 14 McCarthy

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, remardion, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

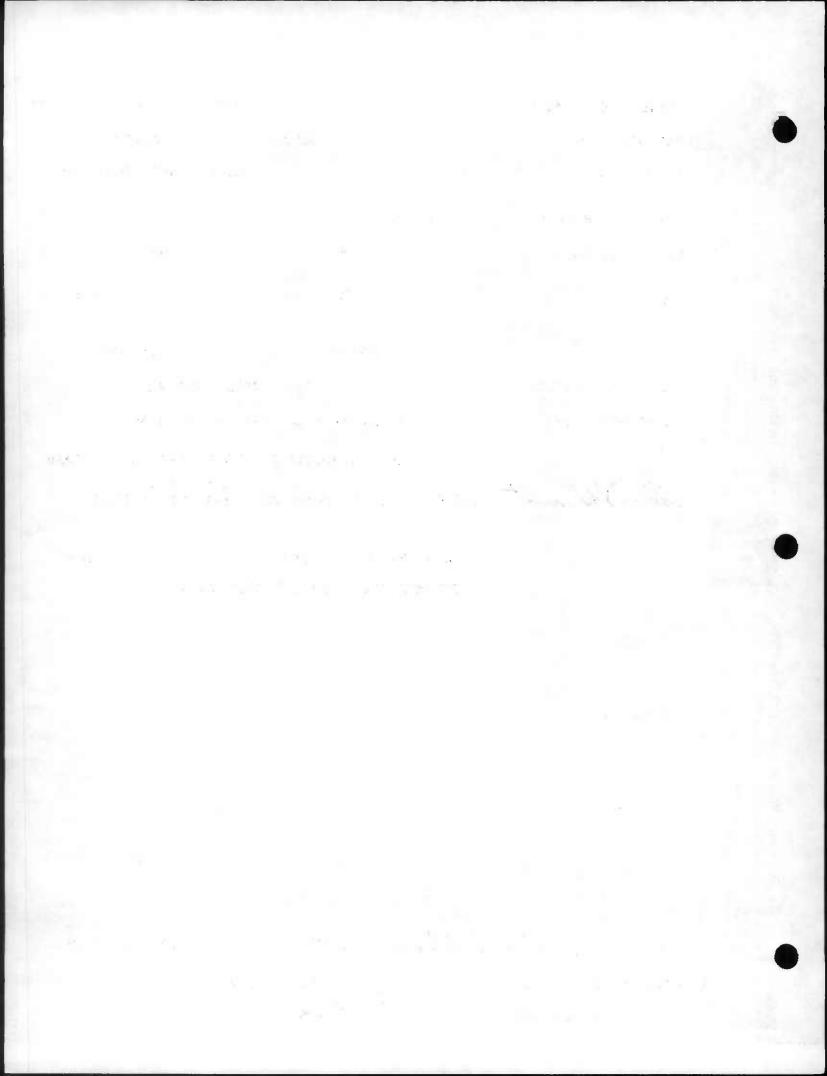
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGIGITIAN		CENTIF	ICATE U	F DEATH	REG. NO).		
1	1. DECEDENT'S NAME (First, Middle, Last)	_				2. DATE OF DEATH	DAY	3. TIME OF DEA	тн
1	MARGARET	E.	MCCA	RTHY				199 10:15	PH
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF BIRTH		B. BIRTHPLACE (State or I	
1	027-07-1173	1 M 2 F	98 VRS.	MONTHS DAY	B HOURS MIN.	(Month, Day, Year)		Country)	
	9a. FACILITY NAME (If not inetitution, give stre		30			8-29-00			AITO
~	the state of the s		1111		N OR LOCATION OF DE			Y OF DEATH	
Ö	ManoKiNN	MONOR	N.H.	Pr. N	cess A	NNE	Son	nersel	_
5	RESIDENCE OF DECEDENT							10, 00,	
DIRECTOR	10a. STATE 10b. COUNTY			Y, TOWN OR LO	CATION			10d. INSIDE CIT	Υ
۵	MD. WORC	ESTER	l B	ERLIN				1 YES 2	NO
7	104. STREET AND NUMBER				101, ZIP CODE		10e. CITIZI	EN OF WHAT COUNTRY?	-
FUNERAL	27 SEABREEZE R	D		2 1	21811			S.A.	- 1
🖁									
5	1 Never Married 2 Merried	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED	13. WAS [ECENDENT OF HISPAN specify Cuben, Mexical	IIC ORIGIN? (Specify Vi	s or No- 1	 RACE — American Ind Black, White, etc. 	lan,
B	3j Widowed 4 Divorced	IF YES, GIVE WAR OR			ES 2 NO Specify			Specific	1
								WHITE	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	TION ompleted)	18e. DECEDENT'S	USUAL OCCUP	TION most of working	18b. KIND OF BU	ISINESS/INDU	STRY	
1 14	Elementary/Secondary (0-12)	College (1-4 or 5+)	We. Do NOT us	vork done during se retired.)	most or working	_			
0	12		Assi	EMBLER		LLEC1	RONI		_
O	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maide	Sumamal		
	EDWARD MORRIS					E COLLIS			- 1
8	19a. INFORMANT'S NAME (Type/Print)								
9					et and Number or Rural F				
1	ELIZABETH HINC	HION	27 :	SEABRE	EZE RD.	BERLIN,	MD.	21811	1
1	20e. METHOD OF DISPOSITION		b. PLACE AND DATE				OCATION — CI	fy or Town, State	
	108 Burial 2 Cremetion 3 Remov		matery, crematory or o						
	21. SIGNATURE OR FUNERAL SERVICE SCEN	MSEE 0 1	LEDAR G		FMFTFRY AND ADDRESS OF FAC		ARODY	· MA	
1	. 11 / .///	110.1							
	- LMWS/1	1/11//		ULLR	ICH FUNE	RAL HOME	BERI	IN, MD.	2181
	23. PART Enter the diseases, or co	molications that cause	ed the death. Do n						
	ahock, or heart fallura. Li	st only one cause on	aach ilna.	or ornar are	mode or dying, add	rea cardiec or resp	matory erre	st, Approxim	
	iMMEDIATE CAUSE (Finsi disease or condition	011	4 .41		w.		•	Onset sn	d Death
	resulting in death)	atterioce	levoter	Car	Liovasci	ulas IZ	un	2 24	10
1			A CONSEQUENCE OF						
z									
CERTIFICATION	Sequentisily list conditions, if any, lasding to immediate	DUE TO (OR AS	A CONSEQUENCE OF	7):			-		
1 X	cause. Enter UNDERLYING								
E	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF	7:					
E	reaulting in death) LAST							Ì	- 1
8	d.							<u> </u>	
	PART ii. Other significent conditions	contributing to death	but not resulting i	n tha undarly	Ing ceusa given in	Part I. 24a. WAS AI	AUTOPSY	24b. WERE AUTOPSY I	INDINGS
EDICAL	Somie. T	1000- 5	t .			PERFO		AVAILABLE PRIOF	TO
ō	01	The acces	7 10 10			1 YES	M.NO	COMPLETION OF OF DEATH?	CAUSE
M	- Curonie C	cural)	Fibril	letin	_			1 TES 2	NO
	DID TOBACCO USE CONTRI	BUTE TO CAUSE (OF DEATH YE	S I NO	UNCERTAIN	1			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT						
1 2		HOSPITAL:	Waster a Flance	OTHER:					
≥	27. MANNER OF DEATH	Inpatient 2 ER/Out			ome 5 Residence				
4		(Month, Day, Year)			NJURY AT WORK?	28d. DEŞCRIBE HOW	INJURY OCCU	RED	
BY	1 Netural 5 Pending 2 Accident Investigation			M 1	YES 2 NO				
	3 Suicide 8 Could not be	28s. PLACE OF INJUR building, atc. (Spi	Y — Al home, farm, a	treet, factory, of	fice	28f. LOCATION (Street	and Number of	Rural Route Number,	
밑	4 Homicide determined	burning, area (ope	outy)			City or Town, State)		
COMPLETED	29a. CERTIFIER	M. T. M. L.							
 	(Check only one)	AN: To the best of my know	wledge, death occurre	d at the time, d	ete end place, end dua	to the cause(e) end ma	nner ee stated	•	
Ö	2 MEDICAL EXAMINER:	On the basis of examination	on and/or investigatio	n, in my opinion	, death occured at the	lime, date end place, e	nd dua to the	ceuse(e) and menner as	tated.
Ш	296. SIGNATURE AND TITLE OF CERTIFIER			20	29c. LICENSE NUM	BER	29d, DATE S	SIGNEO (Month, Day, Year)	
00	Second Che	18.0	2-1	(2)	D 29	202	D	-15 0	,
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF D	FATH (ITEM 27) (T-	Drive)	12-11	, , ,	1 4	7-13 -7	/
. 1	GREGORIOM. BE	LL050 M)	5302	CHINA	BERRY DI	2., SALISE	LRY	MD 2180	
	31. DATE FILEO (NOPPERS) 1944	32. REGISTRAR'S SIG	MAIUHE						
	Maria de la 1444			All as a second					
	ALK 1. 9 1399	Parties -	p. 1	Joans.					

State of Maryland / Department of Health and Mental Hygiene

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	11	1	Part .	11
- 1	1	V	1	1

						Ce	rtificate	OT	Death			Reg. N	lo.		1004
	1. Decede	nt's Name (First, Mide	dle, Last)		AT III						2. Dete of De Month		еу	Yeer	3. Time of Deeth
Physician /Medical	HALL	IE PEARL	MOON	N								22,	1999		2:30 AM
Examiner	4e Fecility	Neme (If not institution	on, give st	reet end nu	mber)				4b. City, To	wn, or Lo	ocation of Deel	th 4	c. County	of Deeth	
	692	SCHELL ROA	D						OAKLA	ND			GARR	RETT	
eral		ecurity Number	6. Sex			vrs. lest birthday)	If Under 1 Months			24 Hrs. Min.	8. Date of Bi (Month, D March	rth ev. Yee	r)	9. Birthp	elece (State or Foreign etry) YLAND
tor		2-8917	101	vl 2√2 F	91	Yrs.			110010	.,,,,,,	March	28	1908	MAR	YLAND
	Usuel Res	Idence of Decedant			100	City Tourn or Le	nation								Od Incido City I imito
ector	337 - 3	10b. Count			100.	City, Town or Lo								- [0d. Inside City Limits 1 ☐ Yes 2 1 No
C C	MD		RETT			OAKLANI									
Director		t and Number					10f. Zip C					10g. C	litizen of V	Whet Cour	ntry?
<u>a</u>	692 5	CHELL ROA	D					215					USA		
Funeral	11. Merita	Stetus	12	Armed Fo		n U,S. 13.	Was Deceder If Yes, specify	nt of I	Hispanic On an, Mexican	gin? (Sp , Puerto	ecify Yes or N Rican, etc.)	0-		e - Americ ck, White,	
		ver Married 2 Ma		1 ☐ Yes If Yes, Gi			1□ Yes 2	No	Specify:				Specify	WH	IITE
d by	3XJW	dowed 4 Divorce	d	Yeer or D	Detes:										
Completed		15. Decede (Specify only high	ent's Educe	tion complated)		16e. Dece (Give	dent's Usuel (kind of work DO NOT usa	done	petion duning most	of work	ring	16b.	Kind of B	usiness/ind	dustry
отрі		ery/Secondary (0-12)		Collage (1-4or 5+)				9d)				OLDI	HOME	
ပ္ပ	8	and the second	4 7 1 1			нс	MEMAKE	K	10.11.0		(P**			HOME	•
B		s Name (First, Middle									e (First, Middle			ne)	
2	JOHN	A. F	ULMER						MAR			BECK			
		ment's Name/Reletion		, Print)							el Route Numi				Code)
To Be C		PH MOON -	SON				SCHEI		ROAD	OA	KLAND,				
5		od of Disposition urlel 2 Cremetion	3 □ Bar	novel from		 b. Place of Disponentary, cre 	netory or oth	of er ple	ece)	i	Dete	20c.	Location -	City or To	own, Stete
and and		onetion 5 Other (110 001 110111	M	100N - B	ECKMAN	CI	EMETER	Y	1/25/99	O	AKLAN	ID, M	ARYLAND
9000	21. Signal	une of Figneral Service	e Licensee			2	2. Name end	Addre	ess of Fecilit	У	PΩ	BO	X 24	3	
8	M	lu W/L	Dear	1	моо	167 I	HRST F	TIN	ERAT. 1	HOME	- OAKI				0
	23a. Pert	I. Enter the disease, o k, or heart failure. Lis	or complica	tions that									, 1110	-133	Approximate
ian	shoo	k, or heart failure. Lis	st only one	cause on e	eech line.									į	Intervel Between Onset end Deeth
cal	Immediata	Ceuse (Finel												i	
ner	disease o rasulting i	r condition n daath)	a.			REBROVAS		AC	CIDEN'	Г				1	WEEKS
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E C	-		b			HEROSCLE		CA	KDIOVA	ASCU	LAK DI	DEAS	E	<u> </u>	
Examiner	Sequantia if eny, laa	lly list conditions, ding to immediate star Undarlying seasa or injury ed events			Due t	o (or es a conse	quenca of):							1	
<u>a</u>	Ceusa. Er	ntar Undarlying seasa or injury	c												
edical Examir	resulting i	deeth) Lest			Due to	o (or as e consec	quence of):							- 1	
. 2			d.,												
<u>a</u>															
Physician	Pert II. Oth	er significant condit	lons contr	ibuting to d	eath but not	resulting in the u	inderlying ceu	ise gi	iven in Pert I				-		o the cause of death?
y Physician	DEN	MENTIA									1	Yes	2 🔼 No	3 Pro	bably 4 Unknow
2 2											0.4 146-			24b W	are autoney findings
leted											24a. We per	s en eu lormedî	topsy	ev	ere eutopsy findings allable prior to
N G														of	mpletion of cause death?
Com											1 🗆	Yes	2 XNo	1[☐Yes 2☐No
director,		ese referred to medic	el						26. Plece	of Deet	th (Check only	one)			
To	examin	ner?	Ho	spitel:	Inpatiant :	2 ER/Outpetie	nt 3 DOA	Ot	thar: 4 Nu	irsing Ho	ome 5 A Ras	sidance	6 □Oth	ner (Specil	(y)
-	27. Manna			28a. Data	of Injury th, Dey Yea	28b. Time o	of 280	. Inju	iry at		28d. Dascribe	how in	jury occur	rred	
	1 (2) No		tigation	(1010)	in, Dey rea	r) Injury	М		Yes 2	No					
e fune ation	2 A	uicida 6 ☐ Could	d not be mined	28a. Place	e of Injury - A	At home, farm, st	reet, fectory,	office)		28f. Location City or To	(Street	end Numl	ber or Run	al Route Number,
Ificatio	3 □ S	datas		bulla	ling, atc. (Sp	acny)					Chy or 10	JWII, OU	ate./		
ertificatio	3 □ S	omicide datar				lmandadas dant	h accurred at	the ti	ime, data en	d place,	end due to the	o colleg	(s) and m	anner es s	teted
al Certification:	3 □ S	omicide datar	ing Phyelo	lan: To the	a bast of my	knowledga, daet	II OCCUITED AL					2 00036	(3) 6110 1111		
letely filled in by the fur idical Certification	3 □ Si 4 □ H	omicide datar	ing Phyelo It Examine	clan: To the	a bast of my easis of exam mer stated	nination and/or in	vastigation, in	my	opinion, dae	th occur	red et the time	, data e	nd place,	and due to	o the ceuse(s)
Medical Certificatio	3 S 4 H	omicide datar	it Examine	r: On the b	a bast of my easis of exam mer stated	nination and/or in	vastigation, in	my	opinion, dae	th occur	red et the time	, data e	end place,	and due to	o the ceuse(s) Dey, Year)
edical	3 S 4 H	omicide datar	it Examine	clan: To the	a bast of my pasis of examiner stated	nination and/or in	vastigation, in	my	opinion, dae	th occur	red et the time	, data e	and place, Date signe	and due to	Dey, Year)
Medical Certification	3 Si Si 4 H	omicide datar iler 1 Certify k only 2 Medica	ier Male	r: On the b	asis of examiner stated	nination and/or in	29c.	Licen	opinion, dae	th occur	red et the time	, data e	and place, Date signe	and due to	Dey, Year)
Medical Certificatio	3 Si Si 4 H	omicide datar ier 1 Certify 2 Medica sture end title a criff	ier n who com	r: On the b	easis of examiner states	(Itam 23e) (Type,	29c. D3	Licen	opinion, dae se number 35	th occur	red et the time	29d. [ond place, Date signe PRIL	and due to ed (Month, 22,	Dey, Year)
pletely fill edical	3 Si Si 4 H	omicide datar iler 1 Certify k only 2 Medica	n who com	pleted ceur	easis of examiner states	(Itam 23e) (Type,	29c. D3	Licen	opinion, dae se number 35	th occur	KLAND,	29d. [ond place, Date signe PRIL	and due to ed (Month, 22,	Dey, Year)



oretta Mountain

Physician

/Medical

Examiner

1. Decedent's Neme (First, Middle, Last)

ORETTA

4a Facility Name (If not institution, give street and number)

Charlestown Care Center Catonsville Baltimore If Under 24 Hrs. If Under 1 Year Months Days 8. Date of Birth (Month, Dev. Year) 9/1/1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) IOWa **Funeral** Days Hours 1□ M 2X F 82 484-07-9132 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location frems 23s or 28s-f show ther must be notified at Director Catonsville Baltimore MD 10e. Street and Number Charlestown Retirement Center Care Center RM # 224 So. 10f. Zip Code 10g. Citizen of What Country? USA 21228 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 ŏ 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher/homemaker Education 4 permit. Pages 1 and 2 should be file. Depertment of Health and Mental Hyg. Important: If them 27 is marked other say injury or other treum-Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Teresa McMannus Edward Brannan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 906 Chestnut Ridge Dr., Lutherville, MD 21093 Jane Rosolio (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/17/99 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial Park 22. Name end Address of Fecility Holloway Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01051 avic Champson 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final EMENTIA disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be asscuted physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 080 jo signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed by 24a. Was en eutopsy performed? 24b. Were autopsy findings available prior to hes 2000 certificeta 1 Yes

Division of Vital Records, P.O. ta after death.

It after death.

It Director: After this certificet of in by the funeral director, pa To the Hospital of within 24 hours af To the Funerel Dicompletely filled in

Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 6 M.D.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Month

4b. City, Town, or Location of Death

April

12,

1999

4c. County of Death

3. Time of Death

10d. Inside City Limits

Approximete Interval Between Onset and Death

EARS

completion of cause of death?

1 ☐ Yes 2 No

white

Yes 2 No

11:30 PM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THIMAIREN CHOICE LANE

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day Year)

Registrar

Be

Medical Certification: To

filled in by

31. Date filed (Month, Day, Year) APR 1 6 1999

5 Pending investigation

6 Could not be

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

32. Registrar's Signature

28c. Injury at Work?

1 Yes 2 No

26. Place of Deeth (Check only one)

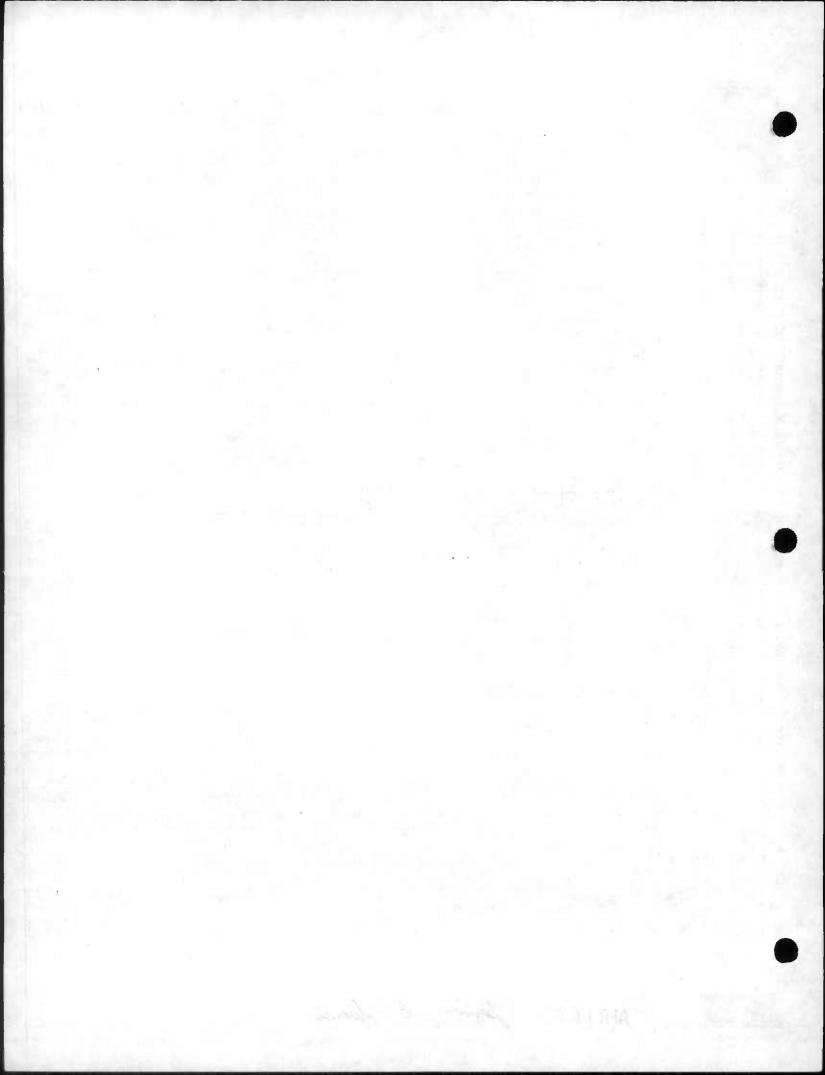
Other:

SNursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

21228



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth MAY MITCHELL April 14, 1999 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not Institution, give street end number) 815A Smith St. Salisbury Wicomico 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dev. Year) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Months Days Hours Min 1□M 213 F 216-07-3932 82 Yrs. November 9,1916 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits X□Yes 2□No Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 815A Smith St. 21801 USA 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Giva Yeer or Detes: 1 □ Naver Married 2 □ Married 1 Yes 2X No Specify: Specify. White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT usa retired) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Poultry/Domestic Poultry Growner/Homemaker 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fathar's Neme (First, Middle, Last) Herman Clarence Henry Maggie Elizabeth Dunn 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Jack H. Mitchell/Son 31702 Hideaway Dr., Parsonsburg, MD 21849 20b. Plece of Disposition (Nama of cemetery, cremetory or other plece) Data 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4/16/99 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory
22. Nama and Addrass of Facility 21. Signature of Ameral Service Licenses Holloway Funeral Home Professional Association 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one ceusa on aech line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) Conduce anut MINJ Due to (or es e consequence of): YRR youth seve (cuchinsulu Sistem Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings avelleble prior to 24a. Wes en eutopsy performed? complation of ceuse of deeth? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide 1 - Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner es steted 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29b. Signeture and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) Conaly M. Juny M 010688

permit. Pages 1 and 2 should be filed within 72 hours efter death v. Depertment of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23a and injury or other traumatic event, the Medical Experient mast a DRGs. **Physician** /Medical Examiner

Physician

/Medical

Examiner

10e State

Maryland

8

Funeral

Director

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r than "natural", or items 23a or the Medical Examiner must be

Director

Funerai

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Completed

Examiner

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Completed

Be

To

1 - Natural

3 ☐ Suicide

(Check only one)

31. Date filed (Month, Day, Year)

29a. Certifier

the Meryland

with

physician end s the buriel-transit the death certificate be executed P.O. Box 68760. attending phy ed by the a signed to Division of Vital Records. The law requires certificate hes b lirector, page 2 s or Attending Physician: efter deeth. Director: After this certifice funeral

Certification: To the Hospital or A within 24 hours elter To the Funeral Direcompletely filled in b edicai

> State Registrar

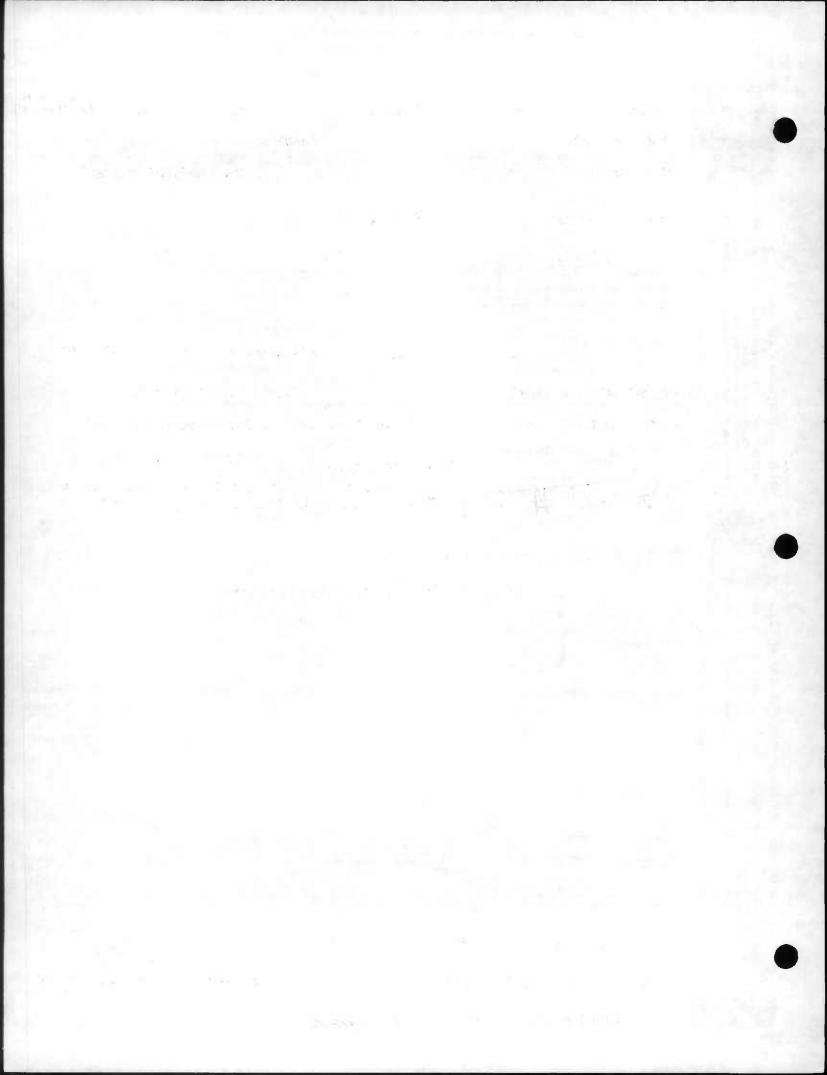
APR 1 6 1999

30. Neme and eddress of person who completed ceuse of death (Item 23e) (Type, Print)



400

Eastern Show Akir, July 14 2 1813



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month A 3. Time of Death Veronica 2155 Miller 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Hospital Baltimore Baltimore University of Maryland If Under 24 Hrs. 8. Date of Birth (Month, Dey. If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 1□M 20%F Months Deys Yrs 73 6/18/1925 Hungary 146-16-4042 Usual Residence of Decedent 10d. Inside City Limits 10e Stete 10h County 10c. City. Town or Location 1X Yes 2 No Wicomico Salisbury 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 200 Atlantic Ave. 21804 USA Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced white 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales person Department Store 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Stephen Nemith Mary Maria Arpasi 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sharon L. White (daughter) 200 Atlantic Ave., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 □ Donation 5x Other (Specify) enteriorent Springhill Mem. Gardens 4/19/99 Hebron, MD 21. Signature of Furieral Service Lig 22. Name end Address of Fecility MOIOSI Holloway Funeral Home 23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel ddys diseese or condition resulting in death) dodomind Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Infection ero colos adhesions formation 12 months isease Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was an eutopsy 2 LANO 1 ☐ Yes 2 ☐ No 1 TYes 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Physician/Medicai by

Certification:

Medical

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Physician

/Medical

Examiner

Director

Funeral

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Funeral

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ortant: if itam 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after or Department of Health end Mental Hygiene. Important: If Itam 27 is marked other than "natural", or ites

Physician /Medical

Examiner

altimore, Maryland 21215-0020

death with the Maryland

25. Wes case referred to medical examiner 1 Yes 2 No

29e. Certifier

Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signeture end title of certif

30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

Greene Street; Baltimore, MD TORRES - ZZ South 460 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

State Registrar

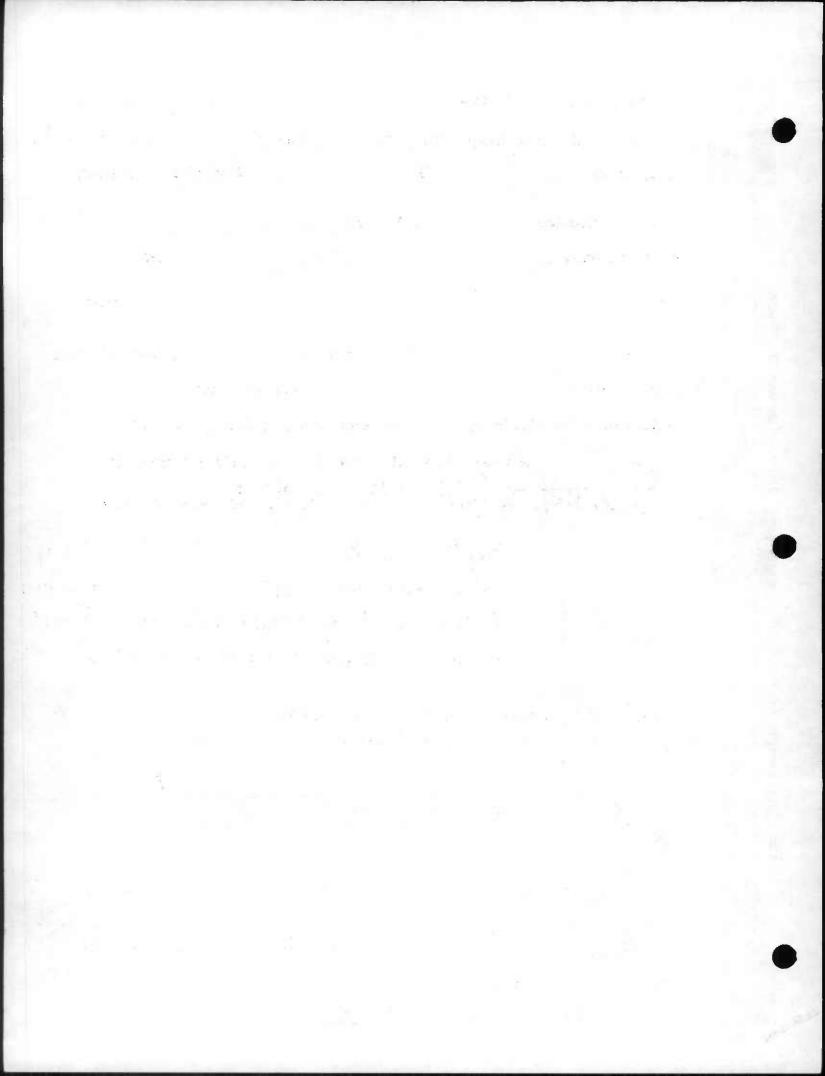
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Division of Vital

To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifice



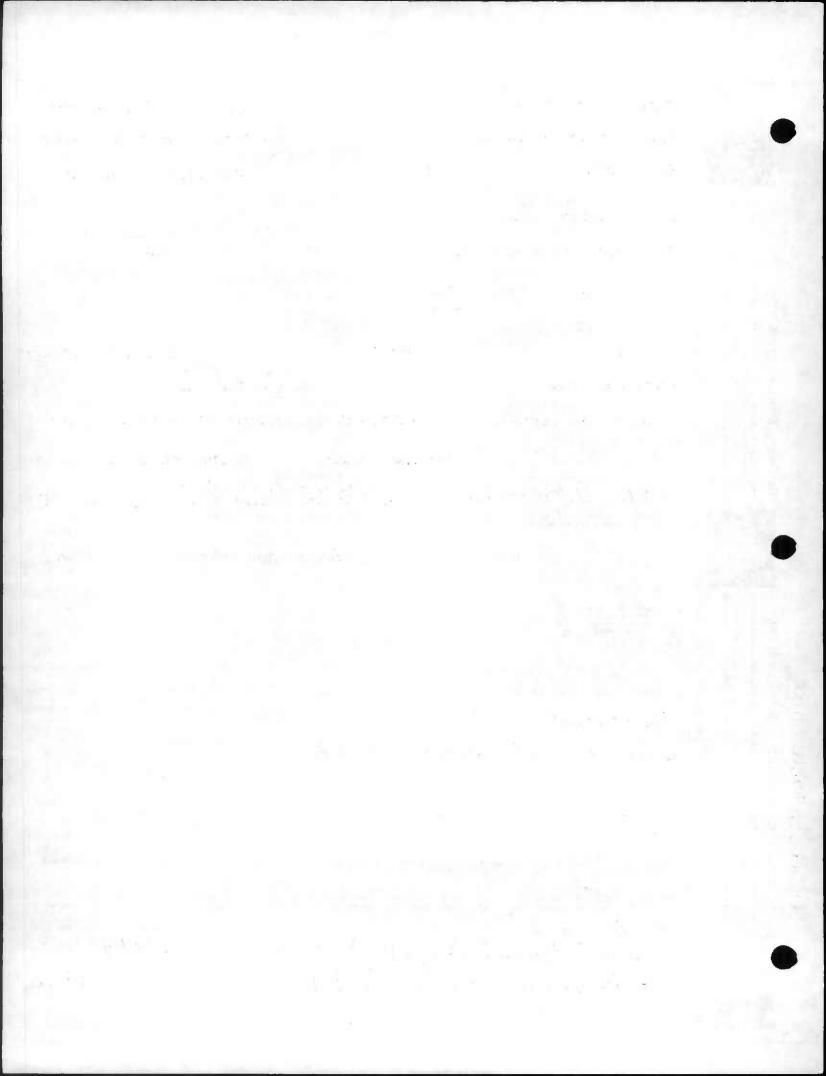
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eath me 23	era	11. Marital Status	12. Was Deceden	t Ever in II	S 13 1	Was Dec	adent of l		pecify Ves or No.	14 Rec	USA e - America	n Indian	
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or A efter Direction by	erti	4 ☐ Homicide determine	building, e	tc. (Specif	y)	eet, racto	ry, once		City or Tow		or or marer	TIOUTO TIDITIDE	,
To the Hospital or A within 24 hours efter To the Funeral Director Completely filled in b	edicai C	29a. Certifiler 1 CertifyIng P	hysician: To the best miner: On the basis	of examine	wledge, death	occurred vestigation	d et the ti	me, dete end plece	, and due to the o	ause(s) end me	nner es ste	eted. the ceuse(s)	
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		30. Name end eddress of person who											
		Dr. V. Datta, 3				own,	Md.	21740					
Sta Registr		31. Date filed (Month, Day, Yeer)	/73.E-w	rer's Signa	iture 9.	1	affect.						

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 14359

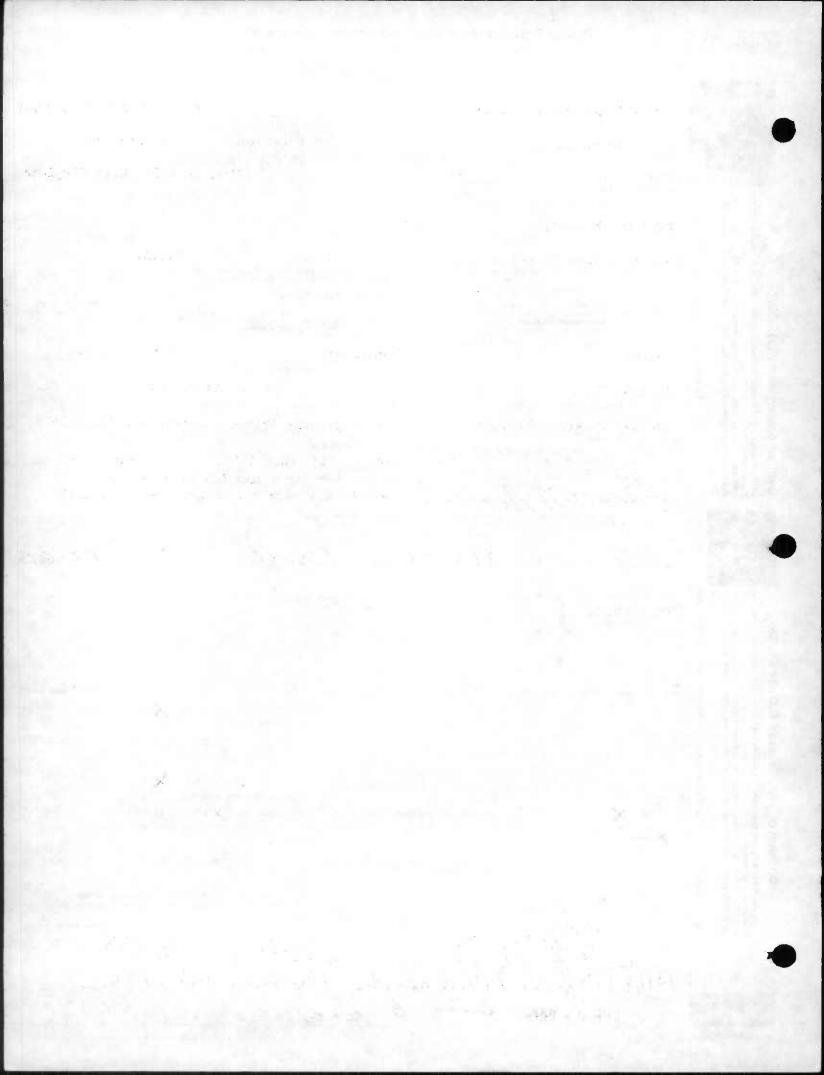
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Harold Ohler McCleaf Medical Examiner	5
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Funeral Director 5. Social Security Number 579–20–3816 1 M 2 F 7. Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. Min. Months Days Hours Min. July 21, 1924 9. Birthplaca (State of Country) Maryland	3.7
Usuel Residence of Decedent	~
To a State 10b. County 10c. City, Town or Location 10d. Inside City	
Maryland Washington Co. Hagerstown	
10a. Stata 10b. County Maryland Washington Co. Hagerstown 10f. Zip Coda 10g. Citizen of What Country? 10a. Stata 10b. County Maryland Washington Co. Hagerstown 10g. Citizen of What Country? 10b. Street and Number 306 N. Colonial Drive, Unit D 21740 USA 11. Marital Status 12. Was Decedent Evar in U.S. Armed Forcas? 15 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
1 Never Marriad 2 Married 1 Types 2 106/20/44 1 Yes, Giva Year or Dates: 02/05/46 1 Yas 2 No Specify: White	
15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16c. Do NOT use retired) 16c. Do NOT use retired) 16c. Do NOT use retired) 16c. Do NOT use retired)	
Elementery/Secondary (0-12) College (1-4or 5+) Bus Driver Public Transporta	tion
8 0 Bus Driver Public Transporta	CIOII
Tr. Fathar's Nama (First, Middle, Last) Charles H. McCleaf Mary A. Carbaugh	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Dorothy T. McCleaf/Wife 306 N. Colonial Dr., Unit D, Hagerstown, MD 21740	
20a. Method of Disposition 1 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Locasee 22. Name and Address of Facility 22. Name and Address of Facility 22. Name and Address of Facility 23. Name and Address of Facility 24. Donation 5 Other (Specify) 25. Name and Address of Facility 26. Date 27. Name and Address of Facility 28. Name and Address of Facility 29. Date 20c. Location - City or Town, State 29. Name and Address of Facility 29. Date 20c. Location - City or Town, State 29. Name and Address of Facility 29. Date 29. Location - City or Town, State 29. Date 29. Location - City or Town, State 29. Date 29. Location - City or Town, State 29. Date 29. Location - City or Town, State 29. Date 29. Location - City or Town, State 20. Location - City or Town, State 29. Location - City or Town, State 29. Location - City or Town, State 29. Location - City or Town, State 29. Location - City or Town, State 29. Location - City or Town, State 29. Location - City or Town, State 29. Location - City or Town, State 29. Location - City or Town, State 29. Location - City or Town, State 29. Location - City or Town, State 29. Location - City or Town, State 29. Lo	nd
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 2	1742
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.	veen
Physician Onset and	Death
Medical Examiner Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cardiovascular disease 20 yr	5
Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying.	
Cause. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Last Due to (or as a consequence of):	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of the	
Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause.	
E 8 TO 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	UNKNOWN
3 Se son se Carcinoma of Urinary bladder 24a. Was an autopsy performed? 24b. Were autopsy available prior completion of completi	0
To the second of	No
25. Was case referred to medical examiner?	
25. Was case referred to medical examiner? 1	
27. Mannar of Death 28e. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 1 1 28d. Describe how injury occurred 1 1 28d. Describe how injury occurred 1 1 28d. Describe how injury occurred 1 1 28d. Describe how injury occurred 1 1 28d. Describe how injury occurred 1 1 28d. Describe how injury occurred 1 1 28d. Describe how injury occurred 1 1 28d. Describe how injury occurred 1 28d. Describe how injury occurred 1 28d. Describe how injury occurred 28d. Describe how injury occur	
Neture	her
28e. Date of Injury - At home, farm, street, factory, office 28d. Describe how Injury occurred	
The state of the s)
29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
1/ Kore C- / Kurash Ph.D. N.D. D17591 4/14/99	
Dr New man 11110 hiedical Campus Road Hagerstown Mar	land
Of the winds the firedical carrigos here the	

DHMH 16 Rav 6/95



AMEND I	TEM: #5 PER G777 11-20-99 WR. Certificate of Death		g. No.	
Physician /Medical	1. Decedent's Name (First, Middle, Last) Ruth Catherine MONTGOMERY	2. Date of Deeth	Day 7	Year 4:52 AM
Examiner	4a Facility Neme (If not institution, give street and number) 4b. City, Town, or L	ocation of Death	4c. County of	
	1112 Sunnyside Drive Hagers			ington
Funeral Director	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	8. Date of Birth (Month, Dey, Feb. 28	Yeer) 3 1922	9. Birthplace (State or Foreign Country) West Virginia
2 ×	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
ment of their steel death with the maryeard than "natural", or items 23a or 28a-f ahow he Modical Evaminer must be notified at ompleted by Funeral Director				1 ☐ Yes 2 ☐ No
or 28a-f a	Maryland Washington Hagerstown 108. Street end Number 107. Zip Code	10	g. Citizen of W	het Country?
D P	0.710		U.S.A.	
r items 234 iliner must Funeral	11 Marital Status 12. Wes Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Si	pecify Yes or No-		- American Indien,
than "natural", or itama 23a or 28a-f ahow the Medical Examiner must be notified at ompleted by Funeral Director	1 Never Married 2 Married 1 Yes 2 No	Rican, etc.)	Specify:	White, etc.
a pa			16b. Kind of Bus	
rt, the Medical	(Specify only highest grede completed) (Give kind of work done during most of work tone during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work during most of wor	king		
	Unknown 0 Homemaker		Her ov	wn home
Be C	17. Father's Neme (First, Middle, Last) 18. Mother's Name	ne (First, Middle, M	faiden Sumeme	a)
To	Lloyd B. Huffman Kate	Blizzard	d King	
traumatic To	19a. tnforment's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Ru	rel Route Number,	City or Town, S	State, Zip Code)
other trau	Jane Lee Powers - Daughter 2377 Pennsylvania Ave			
or other	20a. Method of Disposition 1	Date	20c. Location - 0	City or Town, State
any Injury o	4 Donation 5 Other (Specify) Cedar Lawn Memorial Park	4/9/99 H	lagersto	own, Maryland
any inj	21. Signature of Puneral Service Licensee 22. Name end Address of Facility M 415 E. Wilson Blv	innich F		
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each fine.			Approximate Interval Between
s the buriel-transit edical Examiner	Immediate Cause (Final disease or condition resulting in death) e. Paracockite Caucer Due to (or es a consequence of):			Onset and Deeth
n/Medical Examiner				
Physician/N	Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h Did to	hacco usa con	tributa to the cauea of death?
/ Physician/M	Parts. Other eignificant conditions continuously to death out not resulting in the underlying cause given in rait is	1 🗆 Ye	-	3 Probably 4 Unknown
Completed by F		24a. Was e		24b. Were eutopsy findings available prior to completion of ceuse of deeth?
Com		1□ Ye	s 2000	t ☐ Yes 2 ☐ No
	25. Was case referred to medical examiner?	ith (Check only on	8)	
P 0	Hospital:	ome 5 Reside	nce 6 Othe	er (Specify)
	27. Manner of Death 1. Naturai 5 Pending (Month, Dey Year) 2 Accident investigation 28e. Date of Injury (28b. Time of Injury Work? 1 Pending (Month, Dey Year) M 28c. Injury at Work? 1 Yes 2 No	28d. Describe ho	w injury occurre	ed
<u>=</u> a	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town		er or Rurel Route Number,
edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place end manner stated.			
completely filled in Medical Cert	29b. Signature and title of certifier 29c. License number	2	9d. Date signed	(Month, Day, Year)
o .	D71.80	1	4/51	155
	30. Name and address of person who completed cause of death (ttem 23a) (Type, Prigt)	0	101	//
	Allanders 747 Norton New 14yerta	un M	1 512	742
State Registrar	31. Date filed (Month, Dey, Year) APR 0 8 1999 32. Registrer's Signature 4. Aparell			

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item#29d perPhy G771 5/10/99 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 1999 15. 1200 NORWOOD CALVIN APRIL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner 10512 DINGES BERLIN If Under 24 Hrs. ROAD WORCESTER Birthplaca (Stete or Foreign
Country) 5. Social Security Number 7. Age (In vrs. last birthdav) If Undar 1 Yaar 8. Date of Birth (Month, Dey, Yeer) **Funeral** Min. Months Hours 18 M 2□ F Days Director 3-3-24 permit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Manyland Department of Health and Mantal Hygiana. Important: if item 27 is marked other than "natural", or items 28 or 28a-f show any injury or other traumetic event, the Magical Evantment many. 10b. County 10a State 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 No Director MD. WORCESTER BERLIN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10512 DINGES ROAD 21811 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify WHITE ģ 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) Collaga (1-4or 5+) RAILROAD ENGINEER 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumema) Be JOHN NORWOOD ODIE WATSON 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21045 SON 8331 SILVER TRUMPET DR. COLOMBIA, MD., RICHARD H. NORWOOD 20a. Method of Disposition 20b. Place of Disposition (Nema of cemetery, cremetory or other pleca) Date 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from Stata 4-16 SALISBURY, MD. 5 Other (Specify) SALISBURY CREMATORY 21. Signature of Funeral Service Licensee 22, Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, 23a Part. Enter the disease, or complications that causad the death. Do not enter tha mode of dying, such as cerdiac or respiratory arrest, book, or haart failura. List only one causa on each line. Approximate Interval Batween Onset and Death **Physician** //wedical Immediata Cause (Final diseasa or condition resulting in death) Examine Due to (or as a consaquanca of) Examiner closol physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disaasa or Injury that initiated events rasulting in daath) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of): attanding phi for usa as t signed by the a d be datached f Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of ceuse of death? After this cartificate has funeral director, page 2: 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours aftar daath. Funersi Director: Aftar this cartifica staly filled in by the funeral director, Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 1 ☐ Yes 2☐ No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ ĐOA 27. Manner of Death 28a. Data of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital or within 24 hours aft To the Funeral Di complataly filled in 1 Tertifying Physician: To tha best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature appetition of certifier 29c. License number 29d. Data signed (Month, Dey, Year) 4/16/99 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) BRUKE MD 31. Data filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

APR 1 9 1999

Beneva

Sporks



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 4:25pm Nottingham **Physician** Month Spuern /Medical 4b. City, Town, or Location of Death Snow Hill, MI) 4e. Fecility Name (If not institution, give street and number) 4c. County of Death **Examiner** Nursinglame Snow Hill If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, 5. Sociei Security Number 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** 230-18-0803 1⊠M 2□ F Yrs. Director May 28, 1926 Virginia Usuei Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Virginia 1 ☐ Yes 2 KNo Northampton Machipongo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 7368 James Allen Drive 23405 U.S.A. "natural", or items 23a 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Detes: 11. Meritei Status Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. filed within 72 hours aftar 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorcad Be Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementery/Secondery (0-12) College (1-4or 5+) Self employed truck operator Long Distance 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be I Department of Haaith and Mentel I Important: If Item 27 Is marked of any Injury or other traumatic eve Griffin Nottingham, Sr. 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. informent's Neme/Reletionship (Type, Print) Nottingham, Wife Maggie 1368 James Allen Drive, Box 82, Machipongo, Va. 23405 20b. Pieca of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Baptist Church 4/17/99 Eastville, Virginia 4 ☐ Donetion 5 ☐ Other (Specify) Union 22. Name and Address of Facility John O. Morris Funeral Home P.O. Box 175 Nassawadox, Va. 23413 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physiclan** e. End Stage Simile Dementia of Alzheimer's Type bue to (or es a consequence ot): immediate Cause (Final disease or condition resulting in death) /Medical Examiner Completed by Physician/Medical Examiner buriel-transi Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760 To the Hospital or Attanding Physician: The lew requires that the death certificate be Due to (or es e consequenca of) P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Liovascula 1 | Yes 2 1 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24a. Wes an eutopsy performed? 1 🗆 Yes 2 KNO 1 ☐ Yes 2 No Be 25. Wes case referred to medical examiner? 28. Place of Deeth (Check only one) Hospitei: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA After this 27. Menner of Deeth 28d. Describe how injury occurred 28c. injury at Work? 28a. Date of injury (Month, Day Year) 28b. Time of 1 Neturei 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 Suicide Pieca of injury - At home, farm, street, fectory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner stated. (Check only one) 29b. Signeture and title of certifier 29d. Dete signed (Month, Day, Year) 29c. License number 14. 4-14-99 Name end address of person who completed cause of deeth (item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DRIVE, SALISBURY, MO 21801

32. Registrer's Signeture

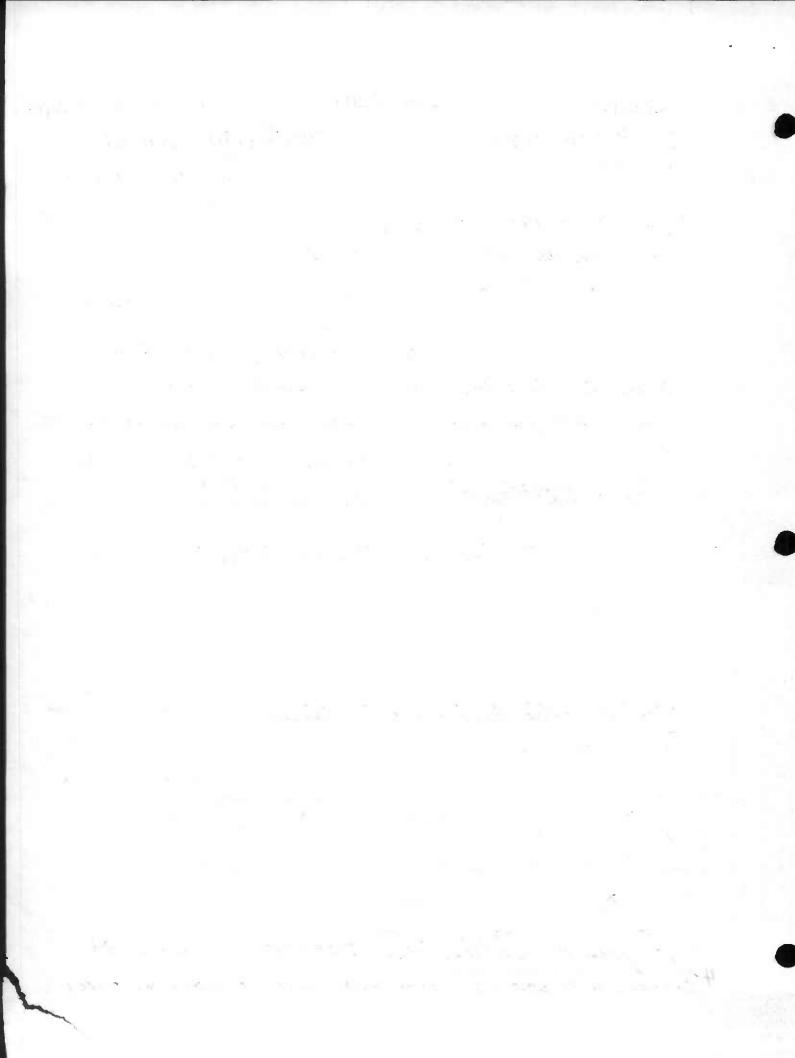
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DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)



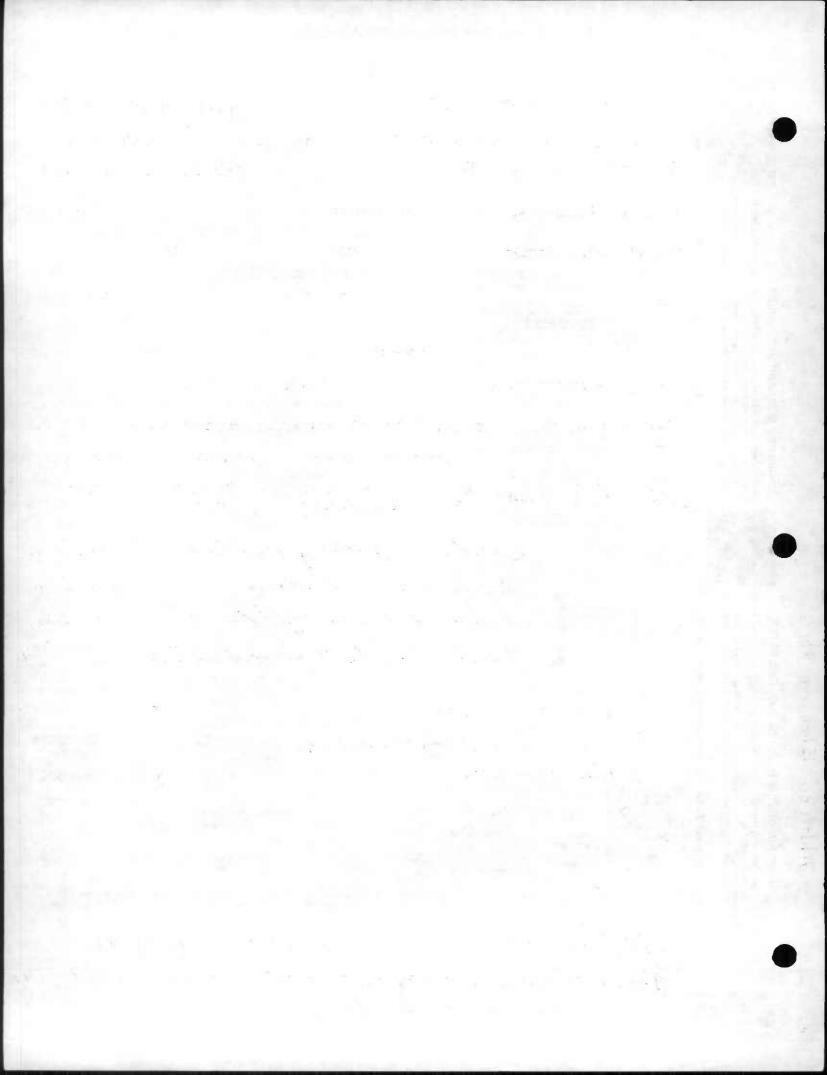
Mildred Eleanor Myt

Physician /Medical	111111111111111111111111111111111111111		April	14 1999 0335
Examiner	4a Facility Neme (If not institution, give street end number)		4b. City, Town, or Location of Death	4c. County of Deeth
Funeral Director	Washington County Hosp: 5. Sociel Security Number 220-09-9079 1□ M 2√2 F 7. Age (In yrs. less 93)		Hagerstown If Undar 24 Hrs. 8. Date of Birth Hours Min. (Month, De) June 23	Washington 9. Birthpleca (Stete or Foraign Country) Pennsylvania
Maryland f show led at	Maryland Washington	Town or Location Hagerstown		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
h with the Ma 3e or 28a-f s at be notified		10f. Zip Coda 21740		log. Citizen of Whet Country?
020 ours after death v self, or literate 234 Examiner mant	3 ☑ Widowed 4 □ Divorced If Yes, Give Yeer or Dates:	13. Wes Decedent of Inf Yes, specify Cub	tispanic Orlgin? (Specify Yes or No- en, Mexican, Puerto Rican, etc.) Spacify:	14. Race - American Indien, Bleck, White, etc. Specify: White
1 21215-0020 and within 72 hours at system. ser than "natural", or it, the Medical Exam	15. Decedent's Education (Specify only highest grede complated) Elementery/Secondery (0-12) College (1-4or 5+)	16e. Decedent's Usuel Occup (Giva kind of work done life. DO NOT use refire homemaker	during most of working	16b. Kind of Business/Industry
yland 21 void be filed with Mental Hygien inked other the file event, the	17. Fethar's Name (First, Middla, Last)	18. Mother's Name (First, Middle, Lula M	home Meiden Sumeme) cCarl	
Mary nd 2 shou tith and M 27 is mer t traumet	19e. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Streat	end Number or Rural Route Numbe	
Pages 1 a ment of Hea ant if Hen.	20a. Method of Disposition 20b. Place 2 Cramation 3 Removal from State	ca of Disposition (Nome of natary, cremetory or other ple enlawn Cemeter	ce) Data	stown, Maryland 21742 20c. Location - City or Town, Stete Williamsport, Marylan
Ball permit Depart Import any in ansa.	21. Signature of Funeral Service Licensee 23. Part1. Enter the diseesa, or complicetions thet caused the deeth. shock, or heart failure. List only one cause on each line.	Gerald N. Funeral Ho Do not enter the mode of dyin	141 1 1 20F 17	Potomac Street stown, Maryland 21740 rest, Approximeter Intervel Between
Physician /Medical Examiner	Immediate Ceuse (Finel disease or condition	respirato	my Failus	
death certificate be executed ettending physician and ad for use es the burist-trensit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	s a consequance of):	ailure ary Edema Nyocardial	Fan Days Fan Days Infarction Pan Days
P.O. de the detach detach	Pert II. Other significant conditions contributing to death but not resulti	1		obacco use contribute to the cause of death? res 20 No 3 Probably 4 Unknown
The law requires the law requires the law seen signed page 2 should be d.	congestive Hea	y Disease of Failu	24a. Was perfo	en eutopsy med? 24b. Were eutopsy findings aveilable prior to completion of cause of deeth?
Vital Rec	Hypertension 25. Was case referred to medical		1 ☐ \	
n of ng Physical distributions of Tree	1 Yes 2 No Hospitel: Inpatiant 2 E	18b. Time of Injury Wo	Yes 2 □ No 28f. Location (5	now injury occurred Street end Number or Rural Route Numbar,
Div	4 Homicide building, etc. (Specify) 29a. Cartifier Certifying Physician: To the best of my knowle		City or Tox	
Divisio To the Hospital or Attendi within 24 hours after deeth. To the Funeral Director: A completely filled in by the it	(Check only 2 Medical Examiner: On the basis of examinetion and manner stated. 29b. Signeture and title of certifier	n end/or investigation, in my o	se number	date end pleca, end due to the cause(s) 29d. Data signed (Month, Dey, Year)
	30. Neme and eddress of person who completed cause of deeth (Item 2	(3e) (Type, Print)	5497 THARESON	4.14.77
State Registrar	31. Dete filed (Month, Day, Year) APR 1 6 1999 32. Registrar's Signetur	6 B. Som	1. UMGEKST	6ND MD 21740
Registrar	APR 1 6 1999	1 17000		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Certificate of Death

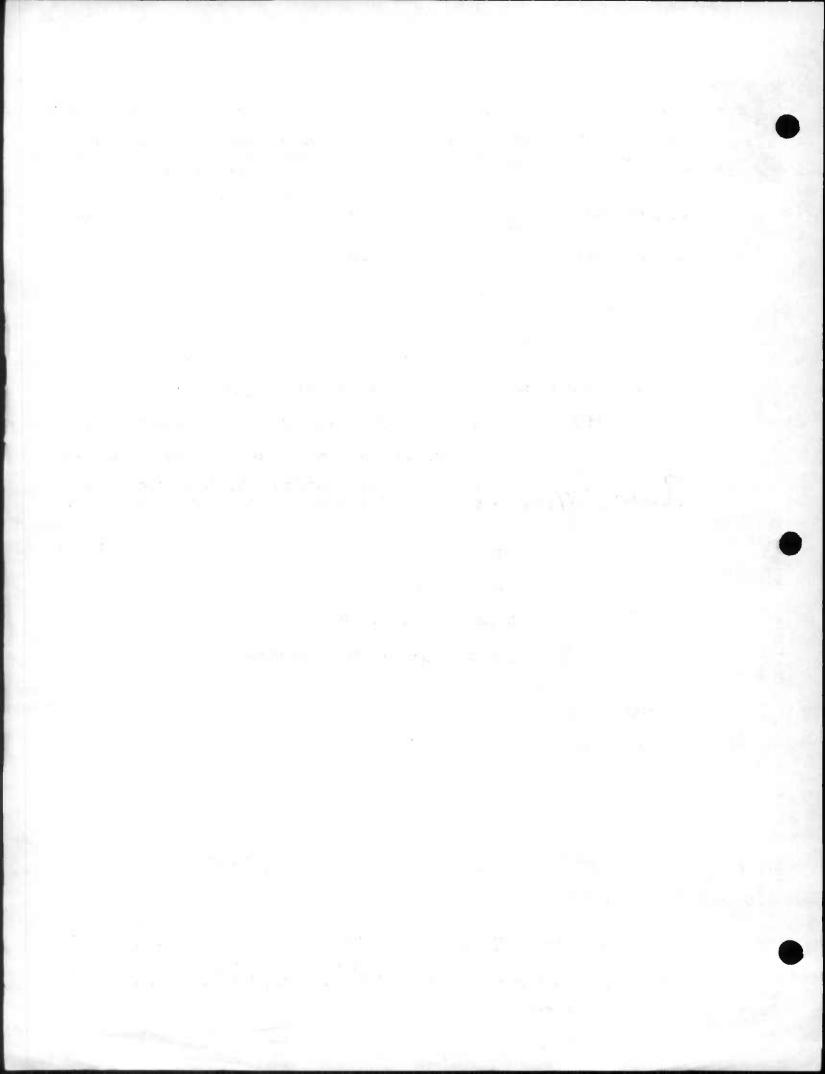
State of Maryland / Department of Health and Mental Hygiene 9 14363



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 36 ly State of Maryland / Department of Health and Mental Hygiene

					iai yiaira		rtificat			R	eg. No.				
	Physic		1. Decedent's Neme (First, Middle,		OV					2. Deta of Dee Month April	th Day	Yeer 999	3. Tima 3:30	ol Deeth	
	/Medi Exami		Helen Virgin 4a. Fecility Nema (If not institution, g Western Marylan)	r		4	b. City, Town, or Hagers	Location of Death	4c. County					
r	Funerai Director				ge (In vrs. les		If Under Months	1 Yaar Deys	If Undar 24 Hrs Hours Min	8. Dete of Birth		9. Birth	plece (Stete Yland	or Foreign	
	g	or	Usual Residence of Decedent 10a. State 10b. County Maryland Washing	ton	10c. City,		ersto	พา					10d. Inside	City Llmits	
	with the ha or 28a-	i Direct	10e. Street and Number 514 Ridge Avenue				10f. Zip	Code		1	0g. Citizen of	What Cou			
020	urs efter death ai', or items 2: From her man	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces	?				ispanic Origin? (n, Mexican, Puar Specify:	Specify Yes or No- to Rican, etc.)	Bla	ce - Ameri ck, White, v: Whi			
21215-0020		Completed	15. Decadent's (Specify only highest s Elementary/Secondary (0-12)		5+)	16e. Deced (Give life.		al Occup rk done o se retired	ation during most of wo	n 16b. K			Kind of Business/Industry		
Maryland 2	id be filed ental Hyg ked other ic event,	To Be C	17. Fethar's Name (First, Middle, La Carl Woodrow	•				ıde F	18. Mother's Ne	me (First, Middle, I		ne)			
ary	mar mar	-	19e. informant's Name/Relationship		_					urel Route Number	r. City or Town.	State, Zi	p Code)		
	1 end 2 Health e em 27 is		Sonny C. Smith	Sor						erstown,					
Baltimore,			20a. Method of Disposition 1 A Burial 2 □ Cremation 3 4 □ Donetion 5 □ Other (Spec	□Removal Irom State	20b. Plac	ea of Disponentery, creme Hil	sition (Nar	ne of other plea	Θ)	Date	20c. Location - Hagerst	City or T	own, Stata	land	
Balt	permit. Peges Department of Important: If I any injury or		21. Signature of Funeral Service Lic	rinnid	2	Fu	neral	Hom		305 N. Hagerst	own, Ma			740	
	Physician		23a. Part1. Enter tha disaasa, or co shock, or heart failura. List on			Do not ent	er tha mod	la of dyin	g, such as cardia	c or respiratory arr	ast,		Approxim Intervel B Onset en	ete etween d Death	
1	/Medicai Examiner		Immediate Cause (Fine) disease or condition resulting in death)	Pneume.	onia								1 Wee	k	
	D #	ner		Rena1	Due to (or e		uenca of):								
, 00,	rificate be executed ng physician end as the bunel-trensit	i Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Conge	Due to (or e			ure				1			
Box 68760,	E De	n/Medical	thet initieted events resulting in deeth) Lest	chror	Due to (or es			ulmo	nary Dis	sease			I I I I I I I I I I		
	death cer ne ettendir ed for use	Physician/I	Pert II. Other significent conditions	contributing to deeth b	out not resulting	ng in the u	nderlying c	euse giv	en in Pert I.	23b. Dld to	bacco uea co	ntribute t	o the caus	of deeth?	
s, P.O	es that the de igned by the 6 be deteched	by Phy	Malnutrition							1074				Unknown	
Records,	aw requir	Completed	Liver Failure							24a. Wes e perforn		8/	/ara autopsy /ailabla prio ompletion of deeth?	r to	
a		e Col	Of Was some plans day and ind							1 □ Ye		1	☐ Yes 2	□No	
Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☑ No	Hospital:	ont 2 🗆 E	l/Outpetien	t 3 DC	Oth	AF.	ath (Check only on		(0	4.1		
sion of	Attending Phy or death. ector: After this by the funeral or		27. Manner ol Deeth 1 Naturel 5 Pending 2 Accident investigati	28e. Dete ol Inju (Month, Da	ıry 28	Bb. Time of Injury	-	8c. Injun Won		dome 5 Reside			(y)		
Division	tai or Att	Certification:	3 ☐ Sulcide 6 ☐ Could not determine	28e. Place of In	jury - At home c. (Specify)	e, farm, str	eet, lactory	, offica		28f. Location (St City or Town	reet end Numb n, State)	oer or Run	el Route Nu	m <i>ber</i> ,	
	To the Hospital or within 24 hours efter To the Funeral Director Completely filled in b	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	hyeiclan: To the best miner: On the basis o and manner st	I axamination	dge, death end/or inv	occurred rastigation,	et the tim in my op	e, date end pleca pinion, death occi	a, end due to the courred el the time, d	euse(s) end ma ate end plece,	anner es s and due t	steted. o the ceuse	(s)	
	To th withir To th comp	Me	29b. Signatura and titla of gertifiar	200	2			3416			9d. Data signa April,		Day, Yaer)		
_			30. Name end address of person who 1500 Pennsylvania	completed cause of ca	death (Item 23 lagerst	Ge) (Type,	Print) W Mary	este land	rn Mary] 21742-	land Hosp -3112/Mob	ital Ce	enter S. Al	Li. M.	D.	
	Sta Registi		31. Date liled (Month, Dey, Year) APR 13	999 32. Registr	ar's Signatur	B.	S	pork	2						

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 2018 PM Phek 1999 - Rederick Junior APRIL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Nema (If not institution, giva street and number) Examiner If Under 24 Hrs. 8. Data sylinth (Month, Day, Year) Hospital Dorchester DORCheSter 5. Social Security Number General 7. Aga (In yrs. last birthday) If Undar 1 Year Months Deys 8. Data & Birth (Month, Dey, Year)

9. Birthplaca (State or Foreign Country)

March 02 1935 Mary land 6. Sax **Funeral** 14-32-1335 102M 2□ F Yrs Director Usuel Residance of Decedent 10a Stete 10c. City, Town or Location 10h County 10d. Insida City Limits 1 1 Yes 2 □ No Dorchester Director ambridge 10e. Street end Number 10f. ZipVode 10g. Citizen of What Country? 2/6/3 504 Street ine Funeral 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☑ Yas 2 ☐ No 11. Marital Status 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amaricen Indien, Bleck, White, atc. the Medical Examiner 1 Never Married 2 Married 1 □ Yes 2 TNo Specify: If Yes, Give Yeer or Detas:/954.1959 Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collage (1-4or 5+) State HOSPITal 12 Mechanic 17. Father's Name (First, Middle, Last) 18. Mothar's Neme (First, Middla, Malden Sumema) Ould be 1 FRED hek innie Dixon 19e. Informent's Neme/Relationship (Type, 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Cambridge, MD. 21613 04-P Street Health em 27 l MARDEII a
20e. Method of Disposition Baltimore, 20b. Place of Disposition (Neme of cametery, cremetory or other place) Data Pages 1 1 Burlel 2 □ Crametion 3 □ Removel from Stete 4/23/99 Cemetery HUKLOCK, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility P.A. HOME TOWELLE C Hevry 510 washington St. Cambridge, MD, 21613

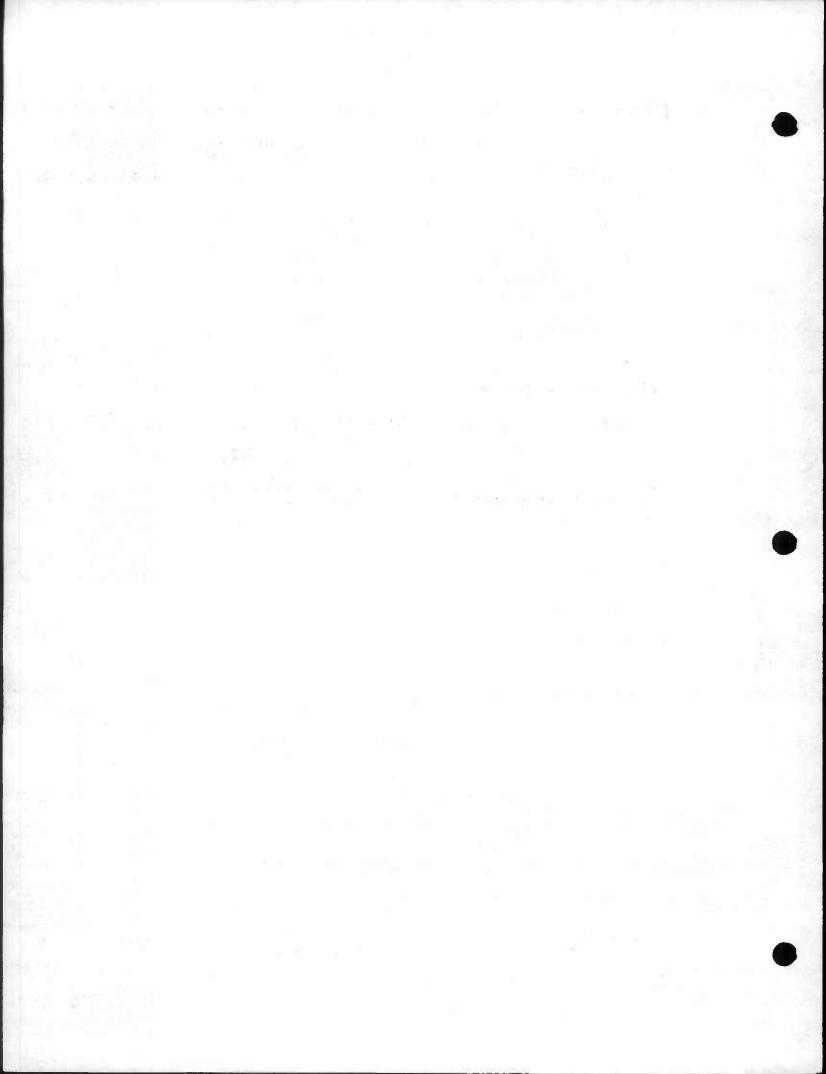
23a. Party Enter the disaasa, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or raspiratory errest,

Approximate

Approximate HENRY Funeral Approximete Intervel Between Onset end Death **Physiclan** End Brase Immediete Cause (Final disaese or condition resulting in daath) renal disease /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner aun ng physician and as the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Entar Undarlying Couse (Diseese or Injury that initiated avants resulting in death) Lest requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, Due lo (or es e consequenca of): 957 Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Peritoneal dialysis. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Was en eutopsy certificate has b irector, page 2 s 1 ☐ Yas 25 No 1 Yas 20 No 25. Wes case referred to medical 26. Pleca of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 25 No 2 After this 27. Megner of Deeth Hospital or Attending Pl
 24 hours after death.
 Funeral Director: After the 28b. Time of 28d. Describe how injury occurred Naturet 5 Pending Invastigation 2 No 2 Accident 3 Suicida 6 Could not be 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicida within 24 hours a To the Funeral D completaly filled 1 Certifying Physician: To the best of my knowladga, daath occurred at tha tima, date end pleca, end due to the causa(s) and mannar as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, daeth occurred at the time, date end plece, end due to the cause(s) end menner steted. 29a. Certifier 29b. Signeture englished 29c. License number 29d. Date signed (Month, Day, Year) D 50987 30. Name end eddress of person who completed cause ol deeth (Item 23e) (Type, Print) med Cumbonder MD Nawaz 105 Amore 31. Dete filed (Month, Day, Year) 32. Ragistrar's Signeture State APR 2 1 1999 Registra

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth Month Day Year April 10, 1999 3. Time of April 10, 1999

1. Decedent's Neme (First, Middle, Last) 3. Time of Death Day 1999 **Physician** Kathleen Cecelia O'Connor 7:45 am /Medical 4a Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 119 Sunflower Drive Hagerstown Washington County 8. Dete of Birth (Month, Dey, Year) If Undar 1 Yaar | If Under 24 Hrs. 5. Sociel Security Number Birthpleca (Steta or Foreign Country) 7. Aga (In vrs. last birthdev) **Funeral** Months Deys Hours 1 M 2 TE Yrs. 579-20-9041 74 Jan.15, 1925 Washington D.C. Director Usual Residence of Decedent with the Maryland r 28a-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Washington Co. Hagerstown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours effar death with Department of Health end Mental Hygiena. Important: If Item 27 is marked other than "--- any highry or other traument. Once. r than "natural", or items 23s or the Medical Examiner must be 119 Sunflower Drive 21740 USA Funeral 12. Was Decedent Ever in U,S. Armad Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indien. Bleck, White, etc. 1 ☐ Yes 2 X No If Yes, Give Yaer or Detes: 1 Never Merried 2 Married 1 Tyes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) UNKNOWN Editor Dept. of Agriculture Unknown 18. Mothar's Name (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Be William O'Connor Alma Burchell 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) Frances Ecton/Friend P.O. Box 452, Funkstown, Maryland 21734 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burial 2 X Cremetion 3 Permovel from State Smithsburg Crematory Apr.13 Smithsburg, Maryland 4 ☐ Donetion 5 ☐ Other (Spacify) 21. Signature of Funerel Service Licenses 22. Name end Address of Fecility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 23a. Pant. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or head failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical andy Examiner consequenca of) Examiner attending physicien and for use as the buriel-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. No 3 Probably 4 Unknown 1 Yes þ 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? been sig 24e. Wes en eutopsy performed? Completed certificata has b director, pege 2 s 1 ☐ Yes 2 ☐ No 1□ Yes or Attending Physician: director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 20 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yes 5 Residence 6 Other (Specify) this 27. Menner of Deeth funerai 28e. Dete of Injury (Month, Day Yaar) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of After 1 Naturel
2 Accident 5 Pending 1 Yes 2 No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. investigation 6 ☐ Could not ba determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Streat and Numbar or Rural Route Number, City or Town, Stete) 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date and placa, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified 30. Nema end, eddress of person who completed cause of deeth (Item 23e) (Type, Print)

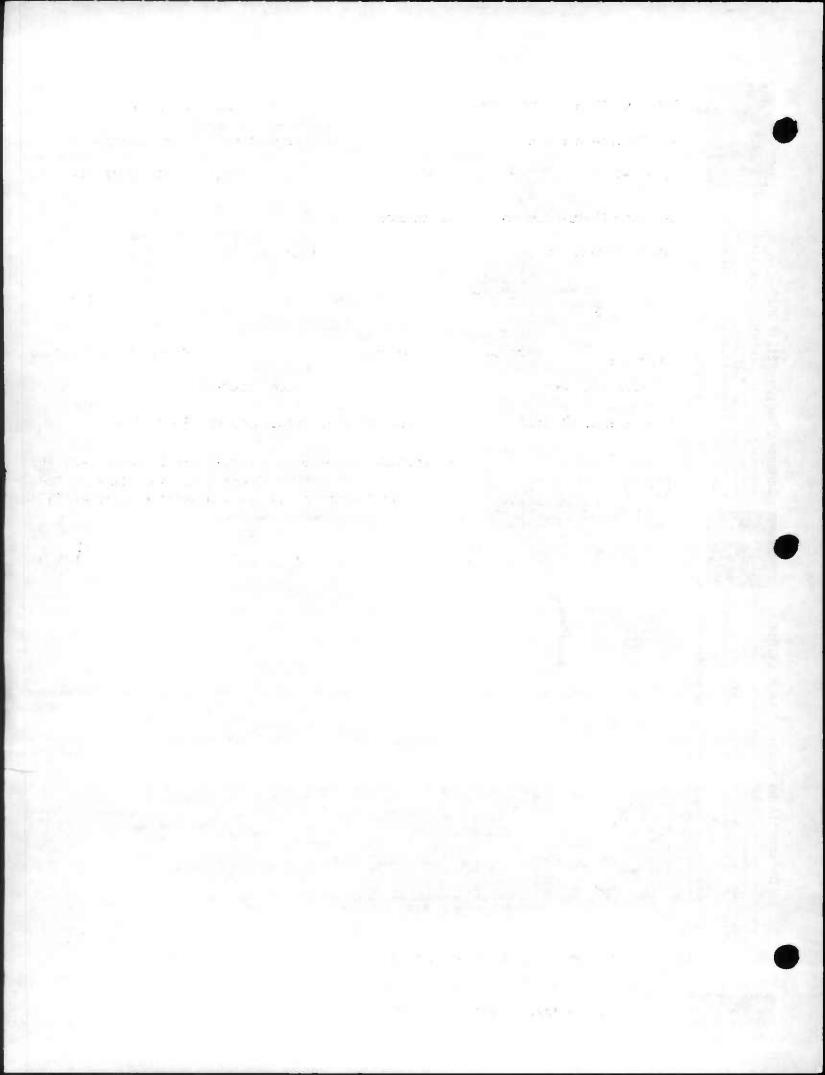
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State of Maryland / Department of Health and Mental Hygiene

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ician	1. Decedent's Neme (First	t, Middle, Las	t)					2. Dete of D Month		Veer	3. Time of Deeth
lical	IMOGENE	TAYL	OR PIER	CE				April	18, 199	9 Year	9:30 A1
ner	4a Fecility Name (If not in	nstitution, give	street end number)				4b. City, Town, or	Location of Dee	th 4c. County	of Death	
	10142 Silve	r Poin	t Lane				Ocean Ci			ceste	
	5. Sociel Security Number			ge (In yrs. les	t birthdey) Yrs.	If Under 1 Year Months Deys		8. Date of B	19,1916	9. Birth	olece (Stete or Foreign
	212 18 6390 Usuel Residence of Deced		[™] ² X 82		110.			April	19,1910	war	yland
	10a. Stete 10b.	County		1	Town or Loca						10d. Inside City Limits
tor	Maryland Wo	rceste	r	Ocea	n City	/					1 □ Yes 2 No
by Funeral Director	10e. Street and Number					10f. Zip Code			10g. Citizen of	Whet Coul	ntry?
<u>a</u>	10142 Silve	r Poin	t Lane			21842			U.S.A	١.	
rune	11. Marital Status 1 ☐ Never Married	Married	12. Wes Decedent Armed Forces? 1 Yes 2 X			as Decedent of Yes, specify Cul	Hispenic Orlgln? (!ban, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)		Race - American Indian, Bleck, White, etc. ecity: White	
2	3 ☐ Widowed 4 ☐ D	ivorced	Year or Dates:								
To Be Completed	15. Do (Specify only	ecedent's Edi y highest gree	ucation de completed)	1	16a. Decede (Give ki	nt's Usuel Occu nd of work done	ipetion e during most of wo ed)	orking	16b. Kind of B	usiness/In	dustry
-	Elementary/Secondary	(0-12)	College (1-4or 5	5+)					Wine	Cha	ese Shop
	12 17. Father's Neme (First, I	Middle, Last)			эпор	keeper	- Owner 18. Mother's Na	me (First, Middl	e, Meiden Sumer		ese snup
	Thomas J.		r					ne Lewi			
•	19a. Informant's Name/Re				19b. Mailing	Address (Stree	et end Number or R			, State, Zij	o Code)
	Kathy P. F	isher			230 S	. Wash	ington S	t. Sno	w Hill, M	ND	21863
	20a. Method of Disposition		Domouri from Chair	20b. Plac	e of Disposi etery, creme	tion (Name of story or other pl	ece)	Dete	20c. Location		
Elementary/Secondary (0-12) 12 17. Father's Neme (First, Middle, Las Thomas J. Taylo 19a. Informant's Name/Relationship Kathy P. Fisher 20a. Method of Disposition Surial 2 Cremetion 3 Conetion 5 Othery/Spec)	Evei		Cemet		4/22/99	Berlin	, MD	
	21. Signature of Fulleral 5	erfice Licens	500		22.	Name end Addi	ress of Fecility		108	Willia	am St.
1	1//-	Q	1								
11/1/4			Tuchal	2	B	URBAG	E FUNER	AL HON	ME Berl	in, A	MD 21811
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	23a. Part . Enter the risk shock, or heart failur	dase, or comp	lications that cause one cause on excel in	d the death.	Do not enter	the mode of dy	ring, such as cardia			in, N	
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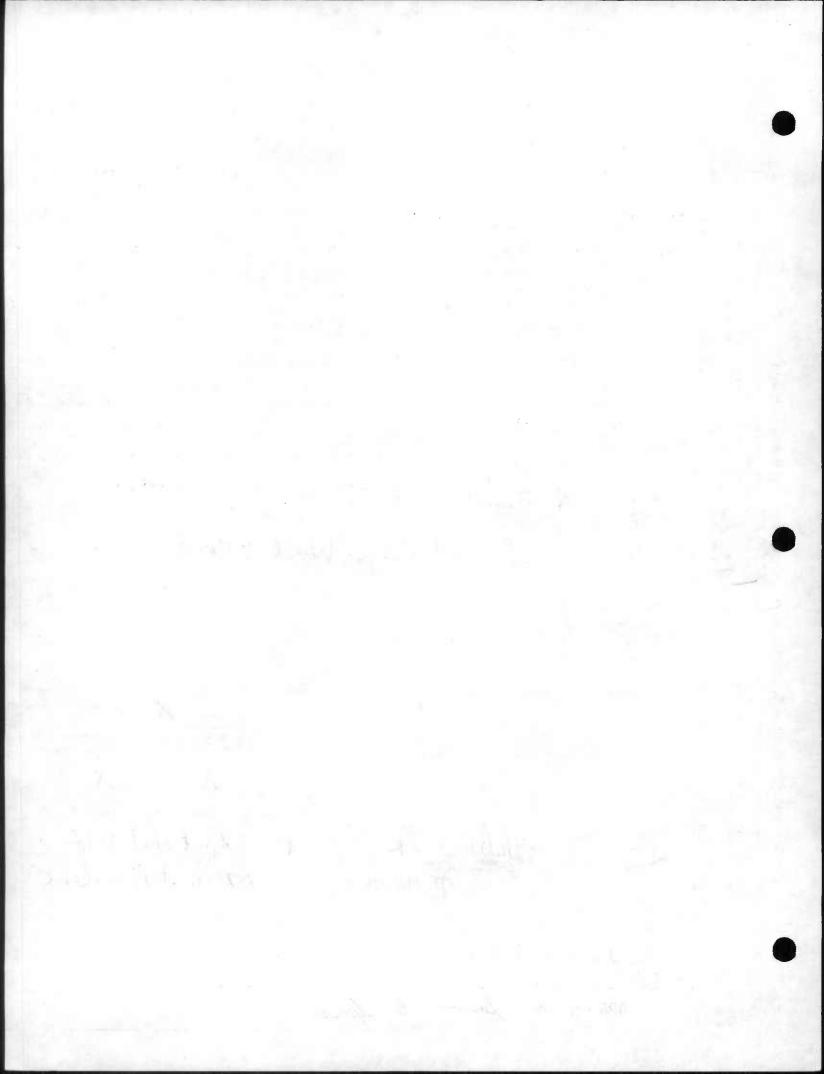
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Herman William Parsons, Jr.

State of Maryland / Department of Health and Mental Hygiene

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			Certili	cate of	f Death		Reg. No.		
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HERMAN	WILLIAM		PARSONS	JR			11, 199		1:35 P.M.
4e Fecility Neme (If not institution, gr	ive street and number)	4.10			4b. City, Town, o	or Location of Deat	-	ly of Death	
7573 Forest Pla	ins Lane				Sali	sbury	Wi	comico	
Social Security Number 6.		(In yrs. la	Mo			rs. 8. Date of Bid	rth av, Year)	9. Birthplac	e (State or Foreig
216-64-9117	X M ZU F	45	Yrs.			March 20	0,1954	Maryl	
10a. State 10b. County		10c. City,	Town or Location	n				10d.	Inside City Limits
Maryland Wicom	ico								1 ☐ Yes 2 ☐ No
-		_					10a. Citizen of	What Country	?
7573 Forest Pla	ins Lane					15 77	_	•	
11. Meritel Stetus	12. Wes Decedent E	ver in U,S	. 13. Was	Decedent of	Hispanic Origin?	(Specify Yes or No	> 14. Ra		
1 Never Merried 2 Merried	1 2 Yes 2 □ N	lo				erto riican, etc.)			
3 Widowed 4 Divorced	Year or Detes:	Army	10	es 2 Laun	о Ѕреспу:		Speci	iy: Wh	ite
15. Decedent's E	Education rede completed)		16a. Decedent's	Usual Occ	upation e during most of w	rorkina	16b. Kind of E	Business/Indus	itry
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27. Manner of Deeth	28e. Date of Injur	y 2	28b. Time of tnjury		jury et /ork?	1	how injury occu		
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Method of Disposition 12 Starial 2 Cremetion 3 Removal from State 13 Danation 5 Coher (Specify) 21. Signature of Funeral Service Licensee 12 Signature of Funeral Service Licensee 13 Part 1. Enter the disease, or complications that Laused the death. Do not enter the mode of desease or condition resulting in death) Last Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of Desease or injury resulting in death) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause of examples or injury resulting in death) Last 25. Was case referred to medical examiner? 25. Was case referred to medical examiner?	7573 Forest Plains Lane 5. Social Security Number 216-64-9117 10suel Residence of Decedent 10s. State 106 County 10suel Residence of Decedent 10s. State 106 County 10suel Residence of Decedent 10s. State 106 County 10suel Residence of Decedent 10s. State 106 County 10s. State 106 County 10s. State 106 County 10s. Street and Number 10s. State 10s County 11. Markel Status 12 Was Decedent Ever in U.S. 11. Markel Status 11 Never Merried 2 Married 11 Norther Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? 11 Never Merried 2 Married 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? 14 Yes, specify Cubian, Mexican, Put Yes 2 No Was 2 No	Social Security Number 6. Sex 216 - 64 - 9117 192 192 192 193 193 194	Social Security Number Sale Security Sale Security Number Sale Security Sale Security Sale Security Number Sale Security	7.573 Forest Plains Lane 5. Social Security Number 216-64-9117 216-64-9117 32 M 2 F 45 45 45 45 45 45 45 45 45 45 45 45 45 4



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Daath 3. Tima of Death 1. Decedant's Nama (First, Middle, Last) BENJAMIN FRANKLIN PAUL 1999 **Physician** Apri 4c. County of Death
WASHINGTON 20:40 4b. City, Town, or Location of Death HAGBR STOWN 4a Facility Nama (If not institution, give street and number) Examiner HOSPITAL WASHIN & TON If Undar 1 Year | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) July 3, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Funeral 10 M 2□ F Months Days Hours 1920 Pennsylvania Director 172-26-9362 Usual Rasidance of Decedant the Maryland 10c. City, Town or Location 10e. Stata 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Wed cal Examinar must be notified as 1 Yas 2 □ No MD Washington Williamsport Direct 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 111 West Potomac St. 21795 Funeral USA 14. Race - Amarican Indien. 12. Was Decedant Evar in U,S. Armed Forcas? 13. Wes Dacedant of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Bleck, Whita, atc. 72 hours after 1 X Yas 2 No 1942 If Yas, Give Yeer or Datas: 1946 1 Navar Married 2 Married 1 ☐ Yas 2 ☒ No Specify: White à 3 ☐ Widowad 4 ☐ Divorced 1946 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 12 should be filed within 72 h end Mental Hygiena. Elementary/Secondary (0-12) Cotlege (1-4or 5+) Driver Trucking 8 0 18. Mother's Nama (First, Middla, Maiden Sumame) 17. Fathar's Neme (First, Middle, Last) permit. Peges 1 end 2 should be Department of Health end Mental Important: If Item 27 is marked or Paul Snowden James Mary E. (unk) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 831 Florida Ave. Hagerstown, MD 21740 Carol Mazingo (daughter) 20b. Place of Disposition (Nama of cematary, crametory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Buriat 2 ☐ Cramation 3 ☐ Ramoval from Stata Injury or Smithsburg Crematory Apr. 17,1999 Hagerstown, MD 21795 4 □ Donetion 5 □ Other (Specify) of Emporal Se 22. Nama and Addrass of Facility OSBORNE FUNERAL HOME P.O.Box # 348 Williamsport, MD 21795 for the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Death Physician /Medical Immadiata Causa (Final disaasa or condition rasulting in death) ARRHY THMIA Examiner Examiner ettending physician and for use es the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Disaasa or Injury that initiated avants rasulting in daath) Last ASUSB TOBACCO Benjamin F. Haul Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaquence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HEART FAILURE, MYDIARDIAC Completed by 24b. Wera autopsy findings avaitabla prior to completion of cause of death? 24a. Was an autopsy performed? INFARCTON 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was case refarred to medical examinar?

1 ▼ Yas 2 □ No Be 26. Place of Death (Check only ona) Hospitat: 1 ☐ Inpatiant Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 0 2 XER/Outpatient 3 □ DOA After this funerel 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No 2 Accidant death. invastigation 24 hours after death Funeral Director: 6 ☐ Could not be determined 3 Suicida 28f. Location (Straet and Number or Rural Route Number, City or Town, Stata) Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar stated. 29a. Cartifian edical completely (Check only one) within 2 29d. Date signed (Month, Day, Year) APRIL 16, 1999 29c. License number 04062 29b. Signature and title of pertifier MO 30. Nama end address of person who completed causa of death (Itam 23a) (Type, Print)

LIKN BY UZICANIN MO, 1923 6 MBROW VIBW OR HABBR STOWN MO 32. Registrar's Signatura 31. Deta filed (Month, Day, Year)

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Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Deeth 1. Decedant's Nama (First, Middla, Last) Month **Physician** 7,1999 4e Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth Kussell 08:46 /Medical 4c. County of Death Examiner Baltimore City
If Undar 24 Hrs. 8. Data of Birth
Hours Min. 8. Data of Birth
(Month, Day, Yaar)

9. Birthplece (State or Foreign of Varyland Uedi 7. Age (In yrs. last birthday) 5. Social Sacurity Number Hedical Center birthday) If Under 1 Year 6 Sex **Funeral** Months Days 1₩ 2□ F 72 July 7, 1926 Director 220 26 3908 Virginia Usual Rasidenca of Dacedant 10c. City. Town or Location 10d. inside City Limits 10a State 10b. County 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Mexical Examiner must be notified at Maryland Worcester Berlin 1 Yas 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10901 Adkins Road U.S.A. 21811 Funeral 12. Was Decedant Ever in U,S. Armed Forcas? 1 2X Yas 2 □ No if Yas, Give Yeer or Datas: WW 1 1 14. Race - American Indian, Black, Whita, atc. Was Dacedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. Maritai Status Peges 1 and 2 should be filed within 72 hours efter of mant of Health and Mental Hygiene.

Intel if item 27 is marked other than "natural", or item.

Intel other traumatic event, the Mexical Execution. 1 Nevar Married 2 Married Specify: White 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratirad) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Fisherman Commercial Fishing 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Meiden Sumeme) Aaron Russell Lulu Holloway 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Doris Powell Russell 10901 Adkins Road Berlin, MD 20b. Placa of Disposition (Nama of cematery, crematory or othar place) 20c. Location - City or Town, Steta 20a. Mathod of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from Stata Department Important: Cape Henlopen Crematory4/18/99 Frankford, DE 4 Donation 5 Other (Specify) Il Service Licensee 22. Nama and Addrass of Facility 108 William St. Burbage Funeral Home Berlin, Maryland 23a. Part1. Enter the disease, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset end Daath **Physician** /Medical Immediata Causa (Final Pistress Syndrous Ken-ratery disaasa or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner sician end buriel-trensit neulumia Saquantially list conditions, if any, laading to immadiata cause. Entar Undarlying Ceusa (Disaasa or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of) physician s the buriel racheoesophasea
Dua to (or as a consequence of): Physician/Medical 98 Dhac ea signed by the elid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No Probably 4 Unknown Cancel þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed ete hes b 1 ☐ Yes 1 ☐ Yas 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifice completely filled in by the funeral director, i 25. Was casa refarred to medical Be 26. Placa of Daath (Check only one) axaminar? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1□ Yes 2 2 27. Mannar of Death 28e. Data of injury (Month, Dey Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Time of Certification: 5 Panding invastigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicida 6 Could not ba 28a. Pleca of Injury - At home, farm, straat, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicide Decrifying Physician: To the bast of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the tima, data and place, and dua to the ceuse(s) end mannar steted. edicai 29a. Certifier

29c. Licansa number

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Department of Surgery, Baltimore 2,201

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32. Ragistrar's Signatura

Creene Street

29d. Data signad (Month, Day, Year)

State Registrar

29b. Signature and titla of cartifiar

31. Date filed (Month)

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ith

30. Name and eddrass of person who complated causa of daath (Item 23e) (Type, Print)

with the Merylend

death

altimore, Maryland 21215-0020

The law requires that the deeth certificete be executed

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene 9 1437

		Ce	ertificate of	Death	F	Reg. No.					
	Decedent's Name (First, Middle, Last)		7		2. Dete of Dea	ith		3. Time of Death			
Physician /Modical	INA WILLIS RILEY				APRIL 2	21, 1999	Yeer	1:50 AM			
/Medical Examiner	4a Fecility Name (If not institution, give street a	nd number)		4b. City, Town, or Lo	cation of Death	4c. County of	of Deeth				
	GOODWILL MENNONITE NU	RSING HOME		GRANTSVIL	LE	GAR	RETT				
Funeral Director	5. Social Security Number 6. Sex 1□ M 2X	7. Age (In yrs. last birthda) F 82 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day MARCH 2	, Year) 29, 1917	Country	e (State or Foreig			
P	Usual Residence of Decedent						1				
a-f ehow	MD 10b. County GARRETT	MT . LAI	KE PARK				10d.	inside City Limit			
or 28	10e. Street and Number		10f. Zip Code			10g. Citizen of W	hat Country	n			
h wif	207 "G" STREET		2	1550		USA					
after death with the Malor items 23a or 28a-1 eminer must be notified if Funeral Director	1 Never Married 2 Married 1 Hr	s Decedent Ever in U,S. ed Forces? Yes 2 🕅 No es, Give	I. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🕅 No	Hispanic Origin? (Spe ben, Mexican, Puerto i Specify:	cify Yes or No- Rican, etc.)	14. Race Black Specify:	- American c, White, etc	.			
reli, o	3 🕅 Widowed 4 □ Divorced Yea	r or Dates:				Орвону.	WHIT	. C			
gas 1 and 2 should be filed within 72 hours after death with the Maryland to I Haalth and Mental Hygiene. If Itam 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade compl Elementery/Secondary (0-12) Coll	eted) (Giv life.	edent's Usual Occu re kind of work done DO NOT use retin	during most of workli	ng	OWN HO		stry			
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oemit. Pagas 1 al Department of Has Important: if Itam: Iny Injury or othe	21. Signated of Funeral Service Licensee		22. Name and Addr								
Deper Impe	Habert 4 Dune	4		ERAL HOME		BOX 243 AND, MD	21550				
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in deeth)	that caused the death. Do not e e on each line. Pulmonary Edema		ing, such as cardiac o	r respiratory ar	rest,	lr O	pproximate iterval Between inset and Death hours			
THE RESERVE	Transmit in deality	Due to (or as a cons	equence of):				-				
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icate be executed physician and s the burial-transit	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):								
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that the derived by the a detached f				Well III Fall I.			3 Probal	6.1			
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tal or Attending Ph is aftar death al Director: After the led in by the funeral Certification: 7	2□ Accident	Placa of Injury - At home, farm, s building, etc. (Specify)			28f. Location (S City or Tox	Street and Numbern, State)	er or Rural F	Route Number,			
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and menner as stated. (Check only one)										
Vithin Fo the comple	E 29b. Signature apolitile of certifier 29c. License number 29d. Date signed (Month, Day, Ye										
F>F0	30. Name and address of power who completes	t a fam) My	D26650		APRIL 2	21, 19	99			
6				WD 01550							
State	Margaret A. Kaiser MD 31. Dete filed (Month, Day, Yea/7	PO Box 486 (32. Registrar's Signature	Dakland,	MD 21550							
Registrar	APR 2 3 1999	10	· jagina	Co.							

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death STETSON 99 1825 JOAN ELIZABETH 4 16 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Deeth CITY WORCESTER OCEAN 414 BERING RD. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 1□M 2 F Months Days Hours Min. 66 Yrs. 138-28-3558 -29-37 N.I Usual Residenca of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits OCEAN CITY MD. WORCESTER 1. Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21842 U.S.A. 414 BERING RD. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 25 KMarried 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) HAROLD EVANS ANN TUGEND 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ALLEN P. STETSON 414 BERING RD. OCEAN CITY, MD. 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 4 □Donation 5 □ Other (Specify) SUNSET MEMORIAL PARK | 4-19 BERLIN, 22. Name and Address of Facility 21. Signature at Funeral Service I ULLRICH FUNERAL HOME BERLIN, Md. 21811 enc 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdlac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ADEMOCARCINOMA OF CONVIL Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of): 23b. Did tobacco use contribute to the ceues of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 25 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpetient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Funeral

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Completed

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Monical Examinat must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death a Depertment of Haelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or harmony or other trauments.

Baltimore, Maryland 21215-0020

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Examiner physician and s the burial-transit Physician/Medical 89 esn attending 10 detached by Completed pege 2 Be 2 Certification:

The law requires that the death certificete be axecuted been signed by should be detact hes certificate To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this certifica funeral director, filled in by

P.O. Box 68760,

Division of Vital Records,

State Registrar

Medicai

completaly

2 Accident 3 Sulcide

4 D Homicide

(Check only

29a. Certifier

295. Surfature and title of certifier 29c. License number 29d. Date signed (Mopth, Day, Year) who completed cause of seath (Item 23a) (Type Frint) Berlin,

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

ealthwal Knue 31 Date filed (Month 32. Registrar's Signature

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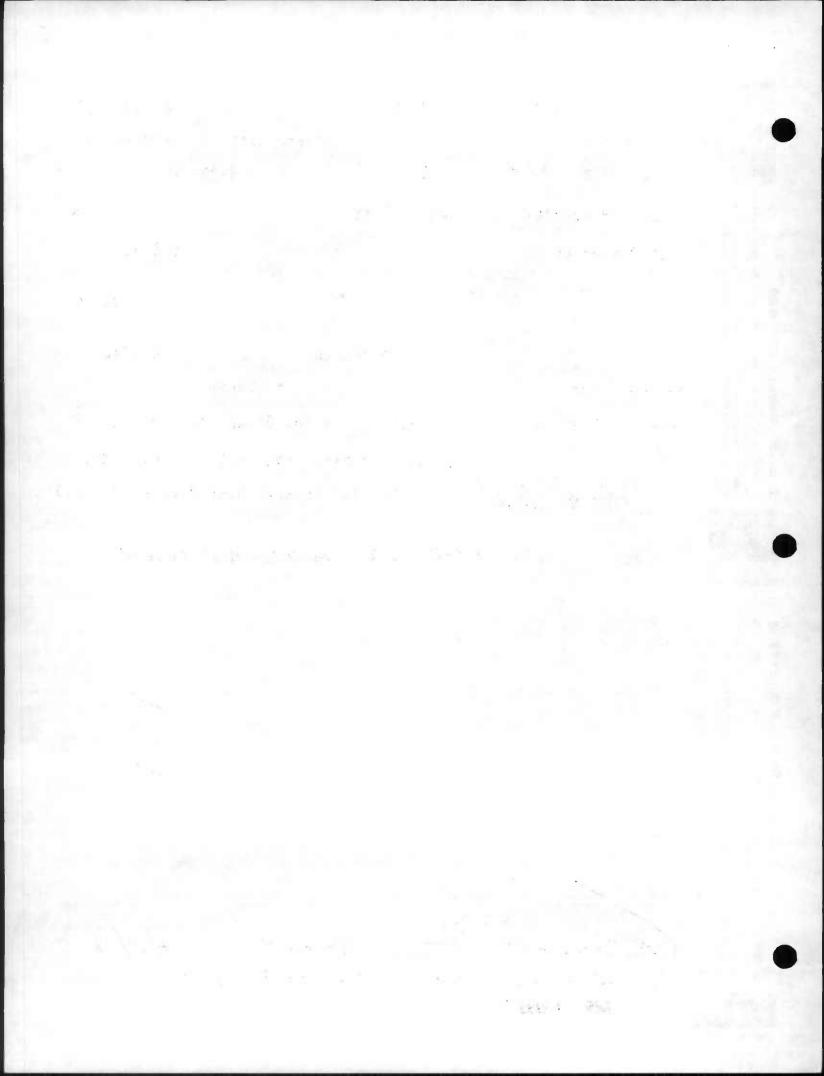
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1 Yes

1 critifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end manner stated.

Location (Street and Number or Rural Route Number, City or Town, Stete)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Samue David Schooltie 0139 99 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. If Under 1 Year Months Days 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Days 100 M 2□ F Hours 215-44-686 Director Usual Residance of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shor 1 ☐ Yes 2 No Funeral Director Norces Ocomoke ter 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9c U_{i} Koac 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 A No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No 7 is marked other than "natural", or traumatic event, the Medical Exam Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: lack Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) grade Maintenance + Sewage treat Water 17. Father's Nama (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill mant of Health and Mantal Hant: If Item 27 is marked oth jury or other traumatic even Schoolticlo stephen Louise tronces 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 20b. Place of Disposition (Nama of cemetery, crematory or other place)
Trivity Church Cemetary Horn town izabe+h altimore. 20a. Mathod of Disposition Date 20c. Location - City or Town, State Burial 2 Cramation 3 Removal from State Department of important: If any Injury or Pocomoke 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
BENNIC Smith Funeral
P.O. Box 337 Pocomol 21. Signature of Funeral Service Licensee Homo Poromoka City md. runce 2/85/ 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final ACUTE ANTERIOR MYOCARDIAL INFARCTION minutes disease or condition resulting in death) Examiner Examiner DRONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last INFARCTION, SIP MYOCARDIAL Box 68760. Physician/Medical Dua to (or as a consequence of): ARREST, ELECTROMECHANICAL DISSOCIATION esn P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION Records, by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed ALCOHOLISM page 2 TOBACCO USE. 1 ☐ Yes 2 No 40 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, 25. Was cese referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 24 hours after death. 2 Accident invastigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowladge, daath occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. Medicai 29a. Certifian (Check only one) within 2 the 29b. Signatura and titla of cartifian 29c. Licansa number 29d. Data signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) lam there Drive Lalis Dala 614-D 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

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Examiner requires that the death certificete be executed P.O. Box 68760, Division of Vital Records,

Examine physician and s the buriel-transit Physician/Medical attending ph ed by the a signed t Ď Completed certificate has b director, pega 2 s Attanding Physician: Be To this funeral Certification: After ours after dea. n 24 hours after des se Funeral Director pletely filled in by th Hospital

Physician

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Baltimore, Maryland 21215-0020

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29c. License number D30035

29d. Date signed (Month, Dey, Year) 04 - 20 - 99

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

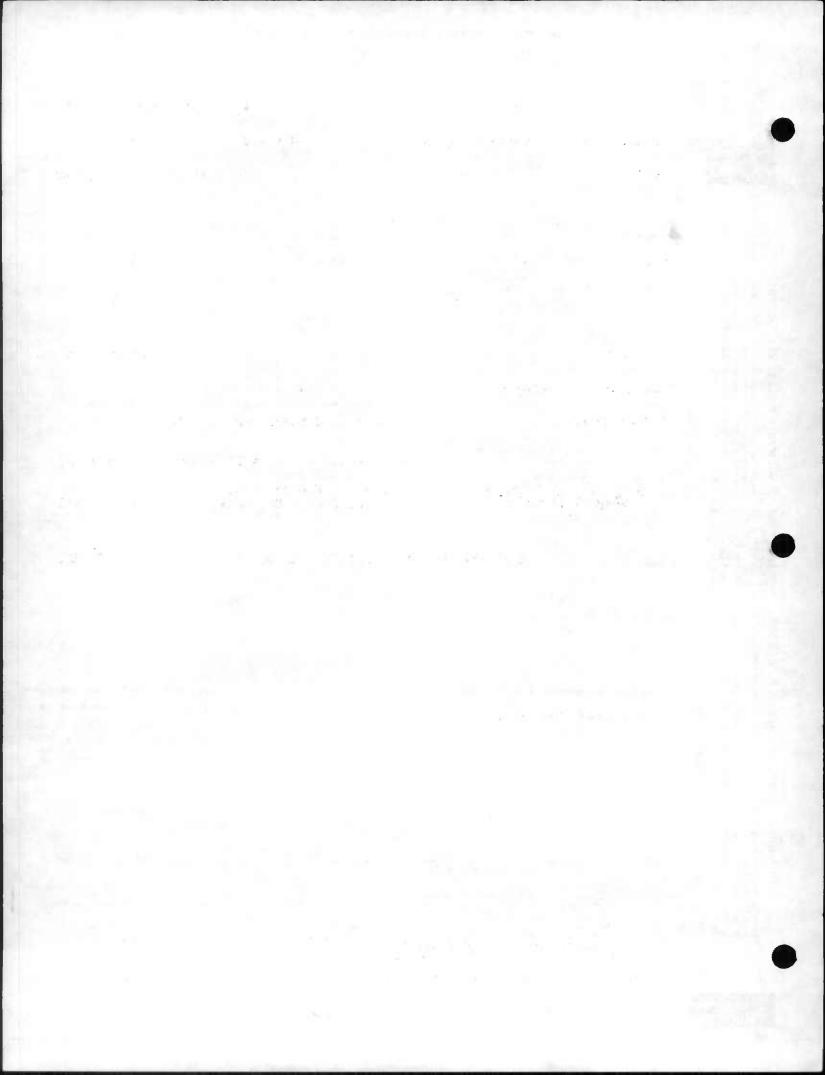
Donald R. Richter MD 1553 Memorial Drive Oakland, MD 21550

31. Dete filed (Month, Day, Year) APR 22

29b. Signeture and title of certifier

32. Registrar's Signature





State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month ADDIE G. SNOWDEN APRIL 14,1999 /Medical 10:30 PM 4a. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 504 PARKER RD. SALISBURY WICOMICO 5. Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) **Funeral** Birthplece (State or Foreign Country) 1□M 20 F Deys Yrs Director 214-10-9998 JAN. 28,1898 DELAWARE Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location ns 23a or 28a-f show 10d. Inside City Limits Director 1 ☐ Yes 🏖 ☐ No MARYLAND WICOMICO SALISBURY 10e, Street end Number 10f. Zip Code 10g. Citizen of What Country? with 504 PARKER RD. 21804 U.S.A. Funeral death Itams 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indien, traumatic event, the Medical Examiner Bleck. White, etc. filed within 72 hours eftar 1 ☐ Never Married 2 ☐ Married 21215-0020 ò 1 Yes 2 No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced 'natural', WHITE Completed 15 Decedent's Education 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) i Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS SHIRT FACTORY Pages 1 end 2 should be filed nant of Haalth and Mantal Hygi int: If Item 27 Is markad other altimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surneme) Be WASHINGTON IRVING PARSONS ELIZABETH ELLEN CAREY 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Haalth a : If Item 27 is or other tra WILLIAM R. ALLEN - SON 2105 THOMAS RUN RD. BELAIR, MD 21015 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremetion 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) WICOMICO MEMORIAL PARK 4/17/99 SALISBURY, MARYLAND 22. Neme end Address of Fecility 705 E. MAIN ST. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, hock, or heart failure. List only one cause on each line. SALISBURY, MD 21804 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final diseese or condition Examiner Examiner DRAHON The lew requires that the death certificate be assecuted the burial-trensit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last Due to for es e consequence of): P.O. Box 68760 physiclan CHRONIC DEMENTIA Physician/Medical Due to (or es e consequence of) usa es Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. by the 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No signed b Records, by pege 2 should Completed 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? peen certificate has 1 🗆 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: director. 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 □ Nursing Home 5 ☐ Assidence 6 □ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA this funeral 27. Menner of Deeth 28b Time of 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury et Work? After 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s aftar death filled in by the 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completaly filled Medicai Til Sertifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

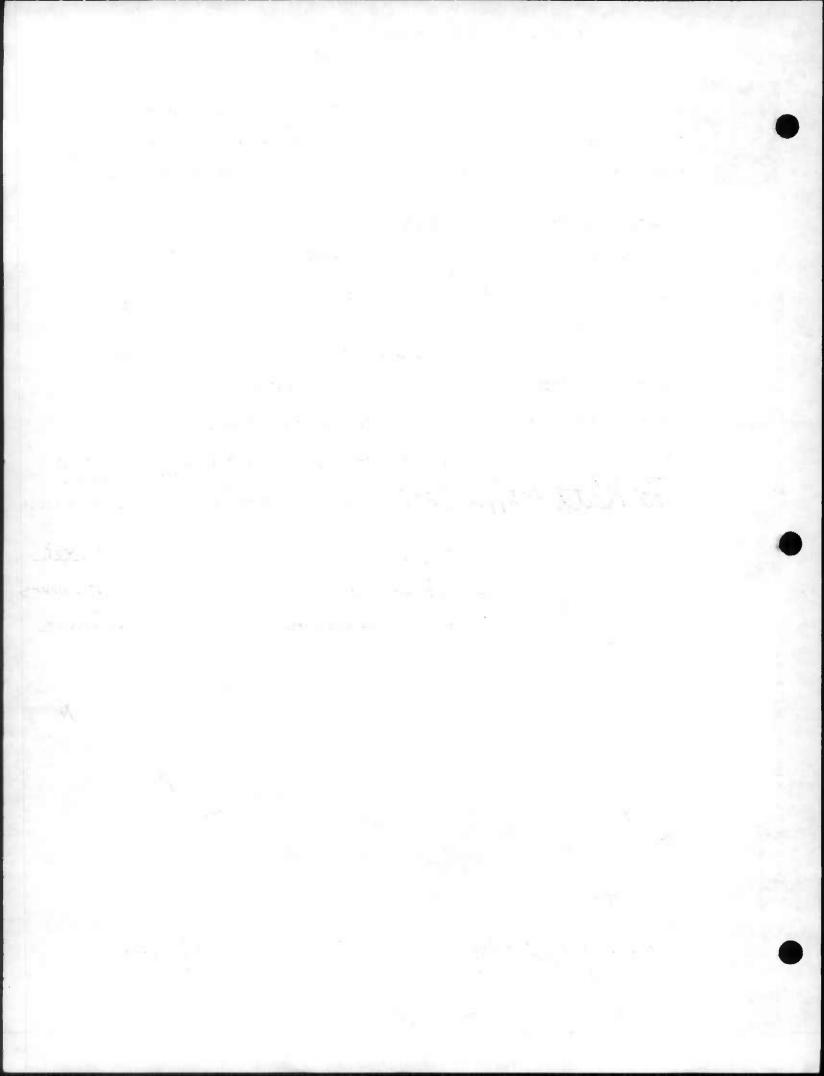
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner stated. 29a. Certifier 29b. Signeture and title of certifier 29c. License numbar 29d. Date signed (Month, Dev. Year) who completed cause of eeth (Item 23e) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

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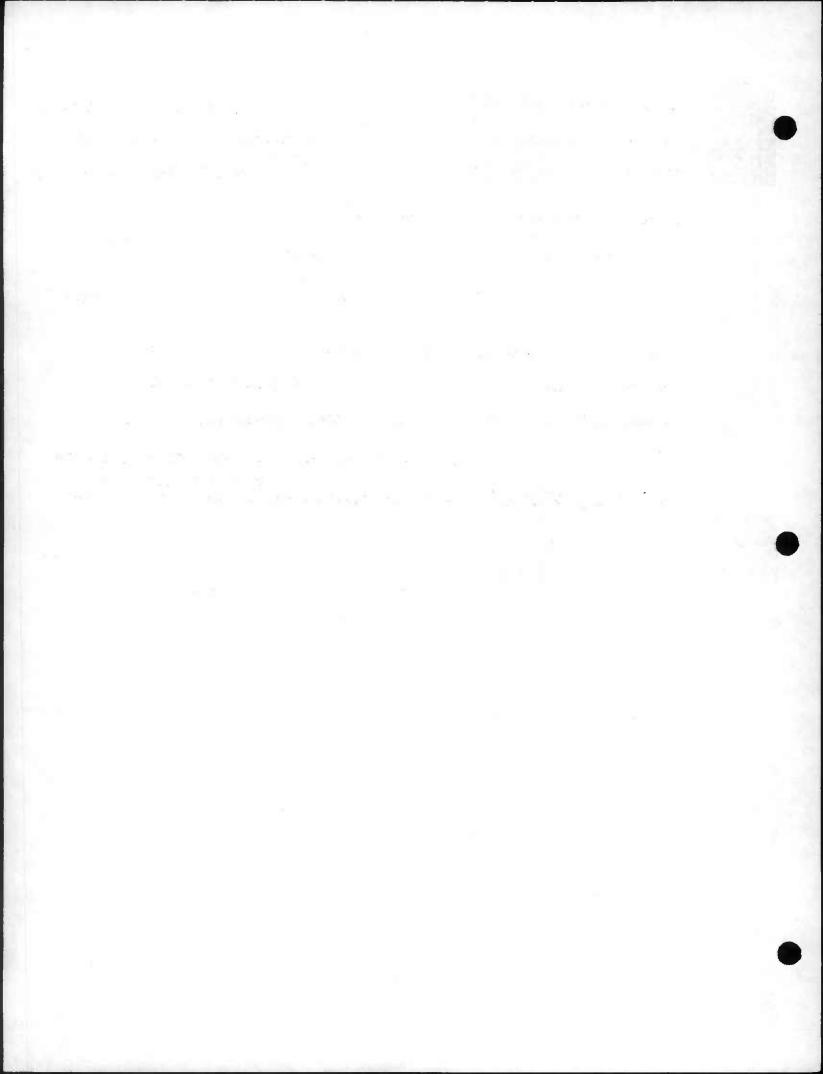
State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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V	/Medi Exami		4a. Fecility Name (If not in	institution, give	street and nu	m <i>ber</i>)				4b. City, Town, o					
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	Funeral		5. Social Security Number		ex □M 2X0 F		yrs. lest birthday) If Under 1 Months	Year	If Under 24 Hr Hours Mir	(Month, I	Dav. Year)	9. Birth	plece (S	tate or Foreign
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	Physician			,											and Death
	/Medical Examiner		fmmediate Cause (Final disease or condition resulting in death)		a		Phenm	sine						12	me
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	문 두 혈	n: T	27. Manner of Death		28a. Date (Mont				c. Injui Wo		_	e how injury occur		iy)	
DIVISION	Attending I r daath. ector: After by the funer	Certification:	1 ☐Natural 5 ☐ 2 ☐ Accident	Pending investigation	(Mont	n, Day rea	ir) Injury	М		Yes 2 □ No					
<u> </u>		tific	3 ☐ Suicide 6 ☐ 4 ☐ Homlcide	Could not be determined	260. Placa	of Injury -	At home, farm, s	reet, factory,	offica		28f. Location	(Street and Numb own, State)	er or Rur	al Route	Number,
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	t hou t hou unar	edical	29a. Certifier 190	ertifying Phy	rsician: To the	best of my	knowledge, dea	th occurred el	the tir	me, date and place	e, and due to th	e ceuse(s) end ma e, date and place,	inner es :	stated.	usa(s)
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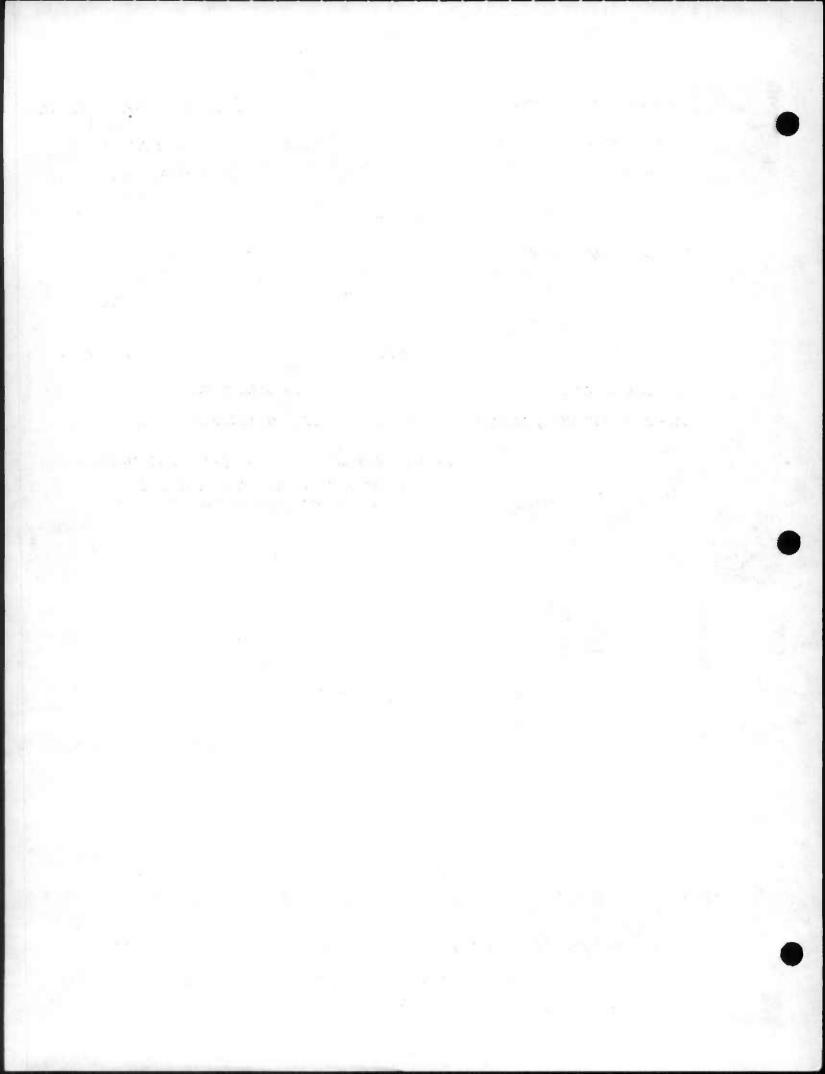
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State of Maryland / Department of Health and Mental Hygiene

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					Ce	rtificate	e of	Death			Reg. No.	a a	
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		COLTON VILLA	NURSING HO	ME				HAGERS		V	WASHI	NGTON	
$_{\rm c}$ Funeral		5. Social Sacurity Number	6. Sax 7.	Aga (In yrs. las		If Undar Months	1 Yaar Days		24 Hrs. Min.	8. Data of Bird (Month, Da	th y, Year)	9. Birthp	place (State or Foreign
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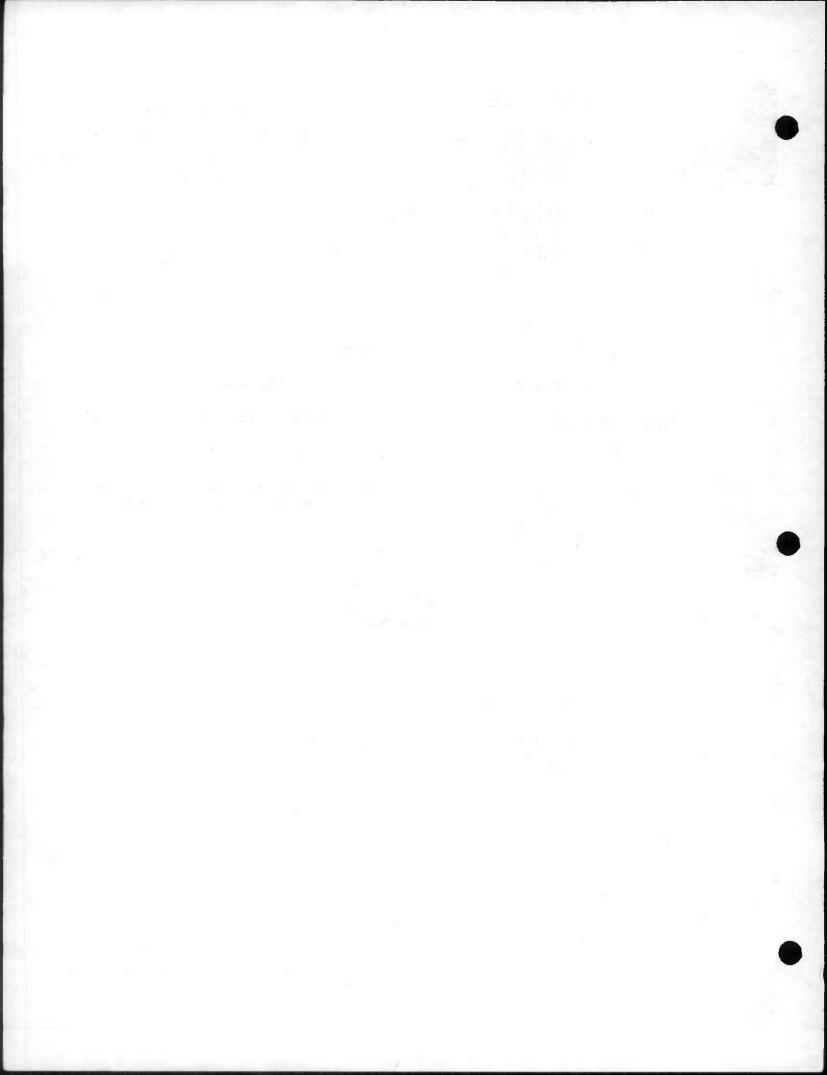


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month 5:26pm Clara Virginia Sharer 14, 1999 April /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Washington Hagerstown Avalon Manor Nursing Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M XIXF 220-10-3963 Director Nov. 22, 1906 MD. Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examinat must be notified at MD Washington Hagerstown 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 21740 10g. Citizen of What Country? 14014 Marsh Pike permit. Pages 1 end 2 should be filed within 72 hours efter death 1 Depertment of Health and Mentel Hygiena. Important: If Itam 27 is merked other than "natural; or itams 28a any injury or other traumatic event. U.S.A. Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Raca - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 white 1 ☐ Yes 2 ☑ No Specify: Specify þ 3 Widowed 4 □ Divorced Completed 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) residence Homemaker 8th grade 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Samuel E. Gruber Annie Laura 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 11400 Stonecroft Ct. Hagerstown, MD 21742 Glendora Burger 20b. Place of Disposition (Name of cametery, cremetory or other place) April 15 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☑ Cremation 3 ☐ Removal from State Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 1999 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc P.O.BOX 310 Clear Sprin

233 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. P.O.BOX 310 Clear Spring, MD 21722 Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner physiclen end the burial-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Records, P.O. Box 68760. Physician/Medical use as signad by the etter Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown à ral vascular disease 24a. Wes en eutopsy performed? 24b. Were eutopsy findings evailable prior to Completed peen completion of cause of death? 1 ☐ Yes 2 ☐ No certificate Division of Vital i or Attending Physician: efter death. Director: After this certifica Be 25. Was cese referred to medical 26. Place of Death (Check only one) examiner's 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funerai 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined To the Hospital or Atte within 24 hours efter de To the Funeral Directo completaly filled in by the 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and menner as steled.

Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Yeer) D44996 April 15, 1999 MD 30. Name and address of person who comp cause of death (Item 23a) (Type, Print Coppans Rd. Boonsboro MD 21713

State Registrar 31. Date filed (Month, Dey, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month **Physician** Sword Gerald April /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Okins Hospital Daltir Daltimore Baltimore ns Birthplece (State or Foreign Country) 5. Sociel Security Number 6 Sex . Age (In yrs. last birthday) **Funeral** Months Deys Hours 1₩ M 2□ F Yrs. 59 MD Director 214-36-0798 May 24,1939 Usual Residence of Decedent with the Maryland 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frame 23a or 28a-f shor traumetic event, the Medical Example: must be notified at Washington MD Clear Spring 1 ☐ Yes 2 ☐ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 13545 Blairsvalley Road 21722 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nant of Health and Mantal Hygiene. Int: If item 27 is marked other than "natural", or items 23. Funeral 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 □ No If Yes, Give unknown Yeer or Dates: Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) State Parks Elementery/Secondary (0-12) College (1-4or 5+) Ranger/Superintendent 12 years years 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) John C. Sword Verda Irene Garrett Jr. 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 10662 Scenic View Dr. Greencastle, PA 17225 David Wayne Sword 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removel from State 6 permit. Page Department of Important: if any injury or pace. Clear Spring, MD etion 5 Other (Specify) Blairsvalley Cem. April 19,1999 22. Neme end Address of Fecility Donald Edwin Thompson Funeral Home, Inc. P.O.BOX 310 Clear Spring, MD 21722

Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate or heart feilure. List only one cause on each line. Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner physician end s the buriel-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, the death cartificete be Physician/Medicai Due to (or as e consequence of): 88 usa 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yee 2 No 3 Probably 4 Unknown þ 8 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed paga 2 hes cartificata or Attending Physician: 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) 1 Yes 2 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1º 2 ER/Outpetient 3 DOA Aftar this funaral 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Naturel
2 Accident 5 Pending after daath. 1 Yes 2 No Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Hoapital Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examíner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner stated. 29a. Certifier Medical (Check only one) within 2 \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0

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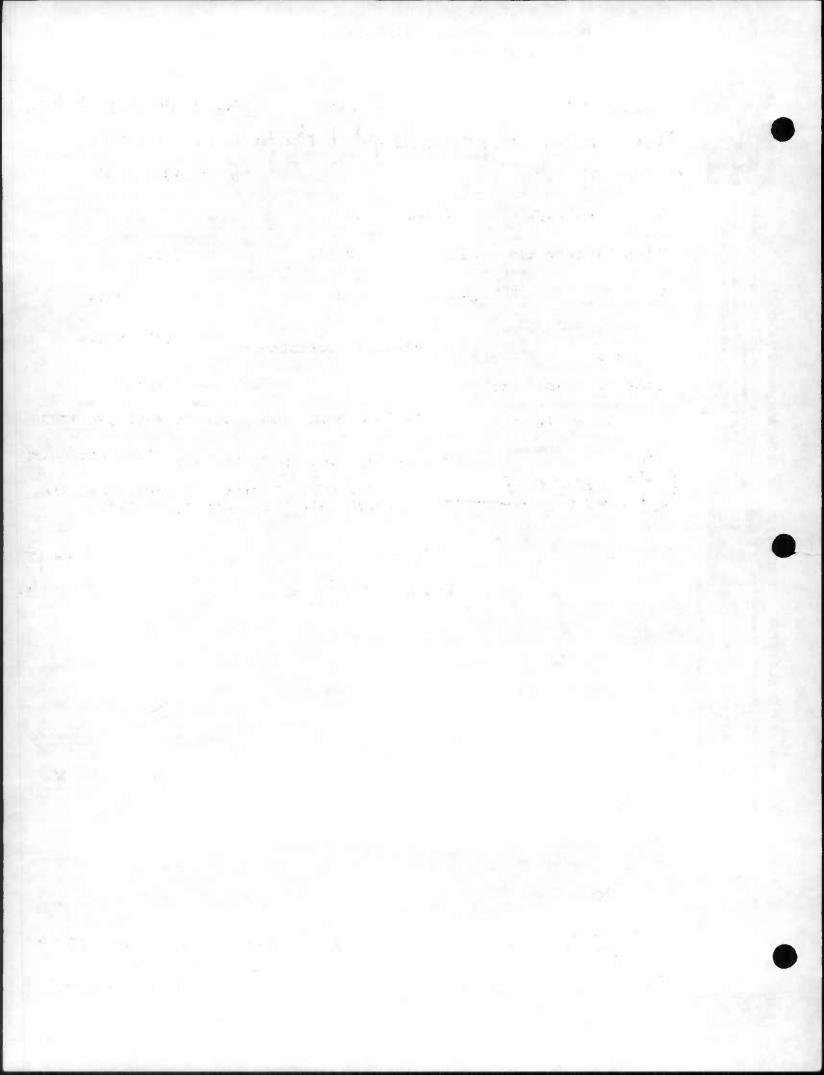
31. Dete filed (Month, Day, Year)

30. Name and will of person who completed cause of deeth (Item 23e) (Type, Print)

30

1 9 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2 Date of Death **Physician** 4b. City, Town, or Location of Death Edgar Lee Stotelmyer /Medical 4a Facility Name (If not institution, give street and number) **Examiner** Washington County Hospital Hagerstown 7. Aga (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1⊠M 2□ F 96 Yrs. Director 214-09-7645 Dec. 22,1902 Usual Residence of Decedent with the Marylend 10c. City, Town or Location 10a. State r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 21740 1032 Rose Hill Avenue Funeral death 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Yes 2 No If Yes, Give Year or Datas: filed within 72 hours efter 1 Never Married 2 Married 1 Yes 2 No Specify:

10d. Inside City Limits 1 XYas 2 No 10g. Citizen of What Country? 14. Race - American Indian Black, White, etc.

15. Decedent's Education (Specify only highest grede completed) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) furniture shop foreman unknown unknown 18. Mother's Name (First, Middle, Maiden Surneme)

17. Fathar's Nama (First, Middle, Last) Harvey Stotelmyer Flora unknown 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)

1030 Rose Hill Ave., Hagerstown, Md. 21740 Robert C. Stotelmyer - son 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 ☐ Cramation 3 ☐ Removal from State Rose Hill Cemetery 4+15-99 Hagerstown, Maryland 4 □ Donetion 5 □ Other (Specify)

21. Signature of Fueral Servica Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Maryland 21740

23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death

3 Time of Death

2345

Birthplaca (Stete or Foreign Country)

white

1999

Washington

Maryland

4c. County of Death

Immediata Causa (Final disease or condition resulting in death)

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Hygiene.

permit. Pages 1 and 2 should be in Department of Health end Mental Important: If itsm 27 is marked or sny injury or other traumatic ever

Physician

/Medical Examiner

attending physician end for use as the burief-transit certificate be executed

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Physician/Medical Examiner

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Certification:

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Due to (or as a consequence of): restingue atherosclerope heart die

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

3₺ Widowed 4 Divorced

OPD Due to (or as a consequence of)

20115

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were autopsy findings available prior to complation of ceuse of deeth? 1 Yes 2 No 1 ☐ Yas 2 ☐ No

4/12/99

25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident

6 ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicida 4 Homlcide

29e. Certifier 斌 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the ceuse(s) and manner es steted. (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) end manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartifier 29c. License number

12 14800 mussels (donle

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) MASSOUD B. ALIZABEH-MD. 240 Brelevick St Hagorstonen, MD 21790 31. Date filed (Month, Day, Year)

State Registrar

APR 1 2 1999

32. Registrar's Signature

Service - I make the first of all a test and a second of the first of a second A SECURE OF THE PROPERTY OF THE PARTY OF THE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Nama (First, Middla, Last) Day Month Yaer Apri Rhonda L. Shreiner 0018 07 1999 4a Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, 11/13/ 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Days Hours Months 10 M 20 F 41 189-46-5154 Pa. Usual Residence of Decedent 10c. City, Town or Location 10d. Insida City Limits 10b. County Yas 2□No Franklin St. Thomas Pa. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 113 Aaron Court 17252 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ≥ 2 ②No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grede completed) Etementery/Secondery (0-12) College (1-4or 5+) Travel Agent Travel 17. Fethar's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Dolores Kriner Harold L. Brake 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 113 Aaron Ct., St. Thomas, Pa. 17252 Curt Shreiner 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State St. Thomas Cemetery 4/10/99 St. Thomas, Pa. 4 ☐ Donetion 5 ☐ Other (Specify) 22 Nama end Address of Fecility 21. Signature of Funeral Sarvice Licensee Kelso-Cornelius Funeral Home, 6492 L.W.W., St. Thomas, 17252 23a. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List *only* one ceuse on each line. Pa. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel anineatic month disease or condition resulting in deeth) Due to (or es e consequence of) Sequentially list conditions, if any, leading to Immadiata cause. Enter Underlying Ceuse (Disease or Injury that initiated avents resulting in death) Lest Due to (or es e consequence of): Dua to (or as a consequenca of): 23b. Dfd tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yea 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy performed?

Physician /Medical Examiner

Department of Important: If any injury or

Physician

/Medical

Examiner

10a. Stete

Directo

Funeral

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Completed

Funeral

Director

with the Maryland

mit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Marylan autmant of Haalth and Mantal Hygiana. Sartmant of Haalth and Mantal Hygiana. Sortmant If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Examines must be notified.

Baltimore, Maryland 21215-0020

Examiner physician and the bunal-transit Physician/Medical 88 usa ed by the a ρχ should Completed paga 2 cartificata

tha funaral diractor, Certification: To Aftar this aftar daath. Director: Aft

25. Wes case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1 Yes 2 → No

27. Menner of Deeth

1 Meturel

2 Accident 3 Suicide

4 Homicide

hreiner, Khonda

24b. Were eutopsy findings eveilable prior to completion of causa of deeth?

1 Yes 2 HNO 1 Yes 2 No 26. Piece of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No Location (Street end Number or Rural Route Number, City or Town, Stete)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end manner as steted.

29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end menner stated. 29b. Signature end title of certifier 29c. License number 29d. Data signed (Month, Dev. Year)

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print)

M'Carmack

Soite 130

State Registrar

Medical

32. Registrat's Signature 31. Dete filed (Month, Dey, Year) APR 0 7 1999

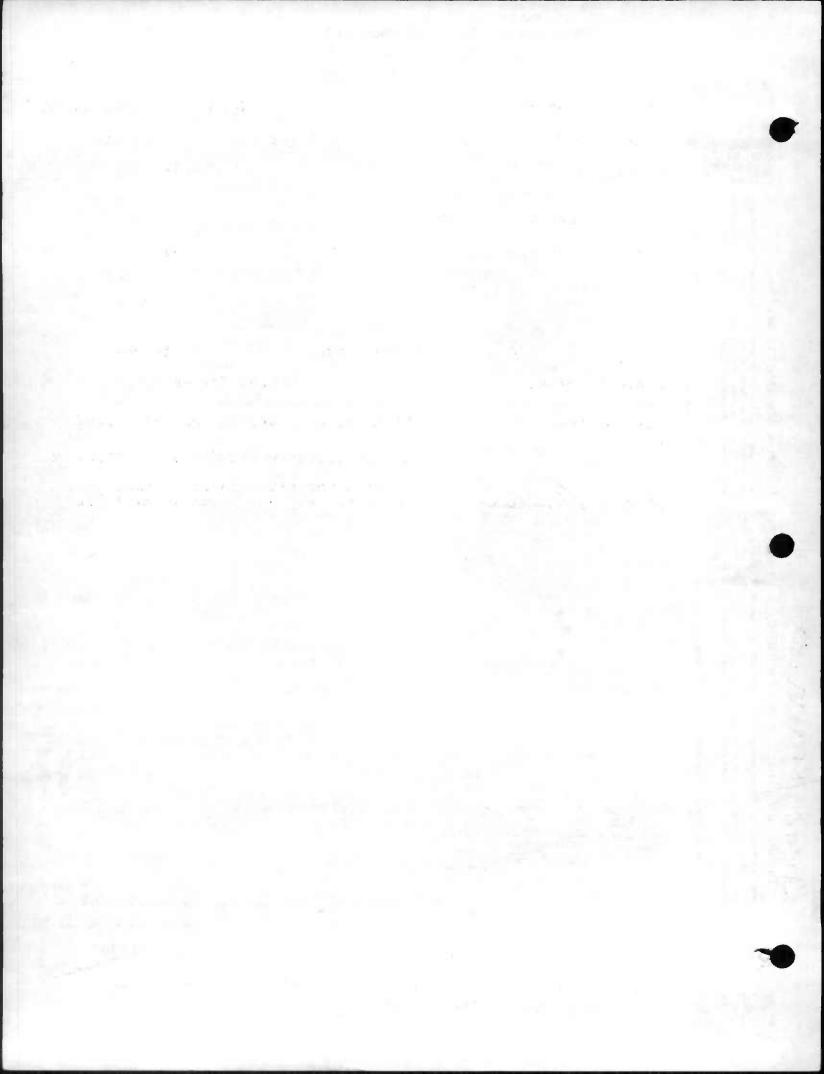
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Hospital or Attending Physician:

24 hours a

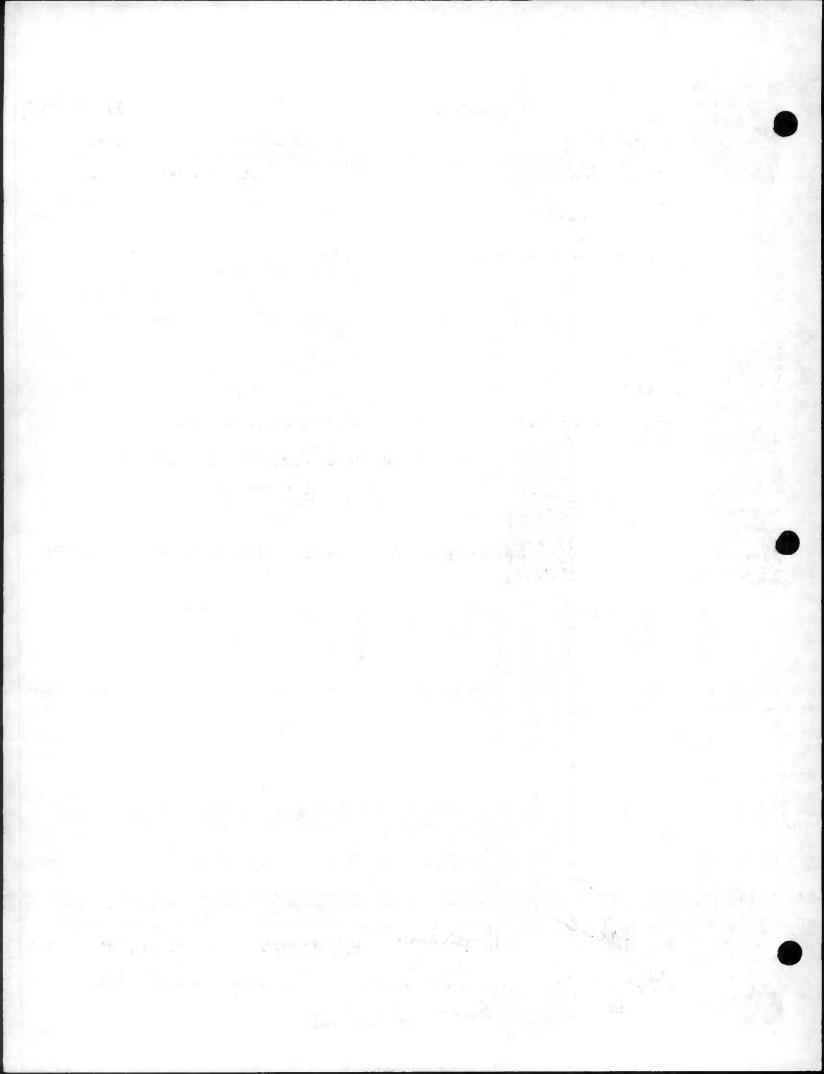
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State of Maryland / Department of Health and Mental Hygiene

					Cert	ificate	of Death		Reg. No.				
Physician /Medical Examine	1	1. Decedent's Name (First, Middle, La	Tho	MA	5			2. Dete of Deam Month	Dey		3. Time of Deeth		
Funeral Director		5. Social Security Number 6. S 155-05-69/2 1 Usuel Residence of Decedent	ex 7. A(ge (In yrs.	lest birthday) Yrs.	If Under 1 Months I	Crisf Year If Under 24 Hr Deys Hours Mir	s. 8. Dete of Birt	th v. Year)	9. Birthpl Count	et lace (State or Foreig try) MD		
ins 23a or 28a-f show Finant be notified at		10a. State 10b. County MD Somers	et		ty, Town or Loca Marion	ation				10	0d. Inside City Limit 1 ☐ Yes 2 🗷 N		
r items 23a or 28a-f s spectrum to notified Funeral Director	al Die	10e. Street end Number 10f. Zip Code 21817 Holland Crossing Rd. 21838								.s.			
of, or he Example	2	11. Marital Status 1 Never Married 2 Merried 3 Divorcad	12. Wes Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:				t of Hispenic Origin? (Cuben, Mexican, Pue No Specify:	Specify Yes or No- rto Rican, etc.)	Ble	ea - America ck, White, e blac	etc.		
1 1 1	חווחומומומ	15. Decedent's Ec (Specify only highest gre Elementary/Secondary (0-12)	5+)	16e. Decede (Give ki life. Do	nd of work O NOT use	occupetion done during most of wi retired)	orking	16b. Kind of B	usiness/ind				
i marked other than umatic event, trained To Be Compl	0	17. Fether's Name (First, Middle, Lest) Archie Jones	18. Mother's Na	ame (First, Middle, Thomas									
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Department of Health moortant: If flam 27 iny Injury or other ti ance	-	20a. Method of Disposition 1 Buriai 2 Cremetion 3 4 Donetion 5 Other (Specific	of or place) Cemetery	Date	20c. Location ·	City or Tov							
Department of Important: If any injury or once.		21. Signature of Europial Service Liper	560		Le	wis N	Address of Fecility I. Watson Fest Rd., Sa	uneral H	ome MD 218	01			
ing physicien end es the burlet-transit and page es the burlet	Medical	Medical	Medical	Immediate Ceuse (Final disease or condition resulting in death) Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest	b	Due to (d	or es e conseque	enca of):	MERS	DEMEN	TIA		SYPS
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s been s 2 should Dieted									24e. Wes en eutopsy performed?		4b. Were eutopsy findings eveileble prior to completion of cause of deeth?		
certificate he rector, page		25. Wes case referred to medical			<u> </u>	-	26. Plece of De	1□ \		1 🗆	Yes 2□ No		
this cerel direction.		exeminer? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2□	ER/Outpatient	3□ DOA	0	Home 5□ Resid		er (Specify)		
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Me samp		29b. Signature and titly of certific	Ph	ysi	ian.		cense number		29d. Date signe	d (Month, E	Pey, Yeer)		
3 F 8 Ording 3		30. Neme and eddress of person who of the first of the fi	ompleted cause of day	KI		int) AG-	1542,550 McCle	early 1	ounda	19	7		



Physician

Examiner

Funeral

Director

/Medical

10a State

MD.

11. Marital Status

Directo

Funeral

by

Completed

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended#24a perFH G771 5/18/99 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yeer ESTHER STANLEY 1999 WARFIELD 18, APRIL 0445 4a Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth ATALNTIC GENERAL BERLIN If Under 24 Hrs. HOSPITAL WORCESTER If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 6. Sex 1 M 2 F Deys Min. Months Hours MD 220-26-6553 Usual Residence of Decedent 90 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ 0 WORCESTER OCEAN CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ANCHOR COURT 21842 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Raca - Americen Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes 2 No Specify: 30 Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) ROBERT LEE STANLEY ALMA PURDUM 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10481 GOLF COURSE RD , OCEAN CITY, Mp., 21842 ROBERT E. WARFIELD SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burlal 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SALISBURY CREMATORY 4 - 19SALISBURY, MD. 22. Name and Address of Facility ULLRICH FUNERAL HOME BE Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. BERLIN Approximate Interval Between Onset end Death Immediate Cause (Final Clack disease or condition resulting in death) Due to (or as a consequence of): Due to (or es e conseguenca of) 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown lumonia 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was en eutopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Ecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es steled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Examine Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Be 25. Wes case referred to medical exeminer? 10 1 Tyes 2 No 27. Manner of Death Certification: 1 Natural 2 Accident 3 Suicide 4 ☐ Homicide edical 29a. Certifier (Check only one) de 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

SILIZ

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 9733 Helthuce

31. Date filed (Month, Day, Year) APR 1 9 1999

32. Registrar's Signature

State Registrar

funeral

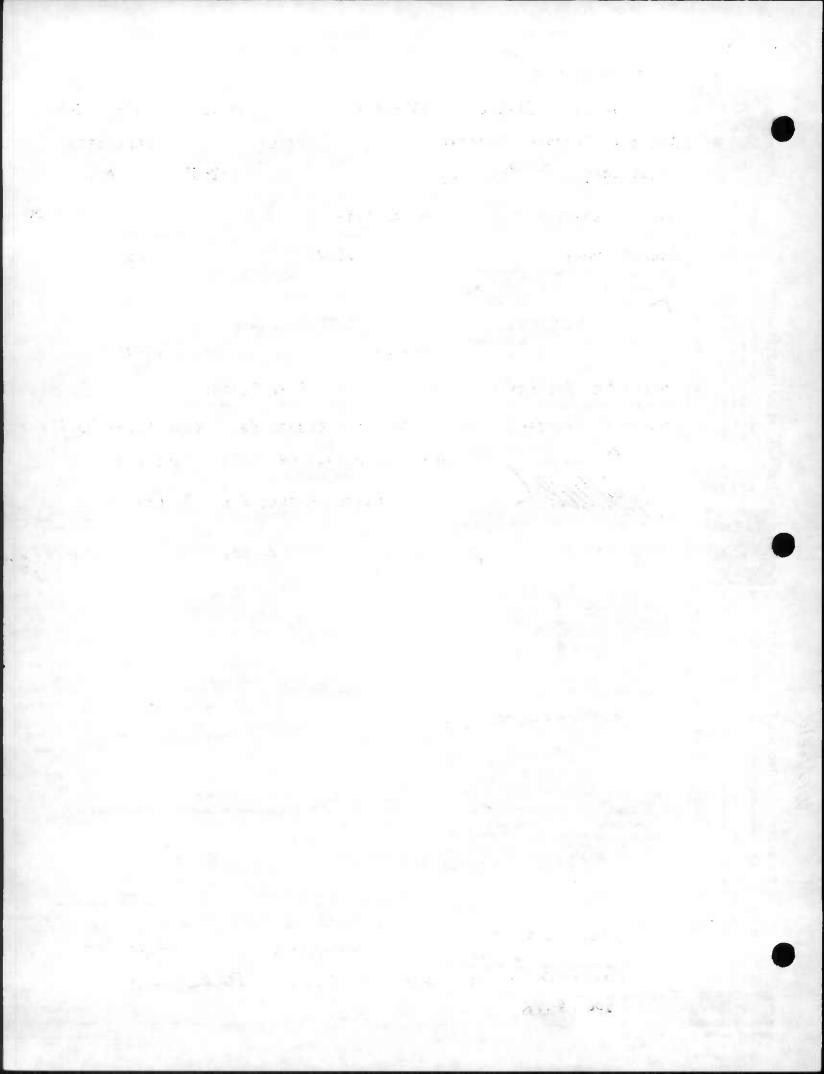
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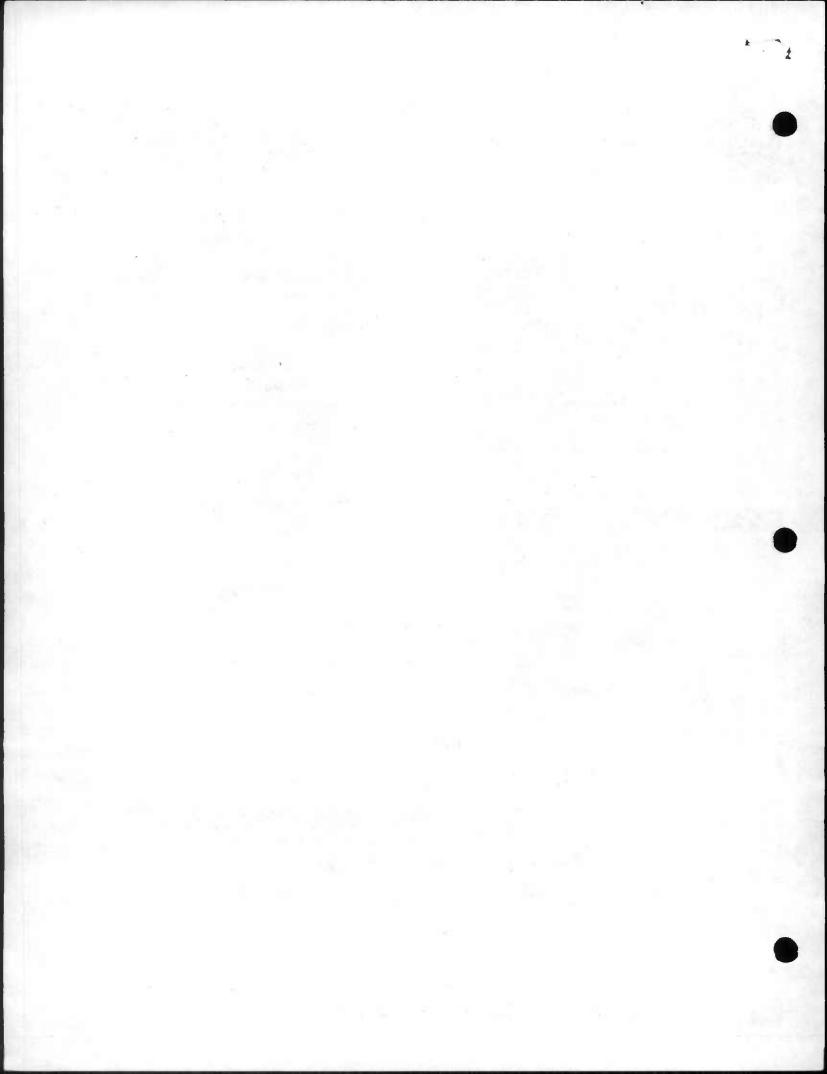
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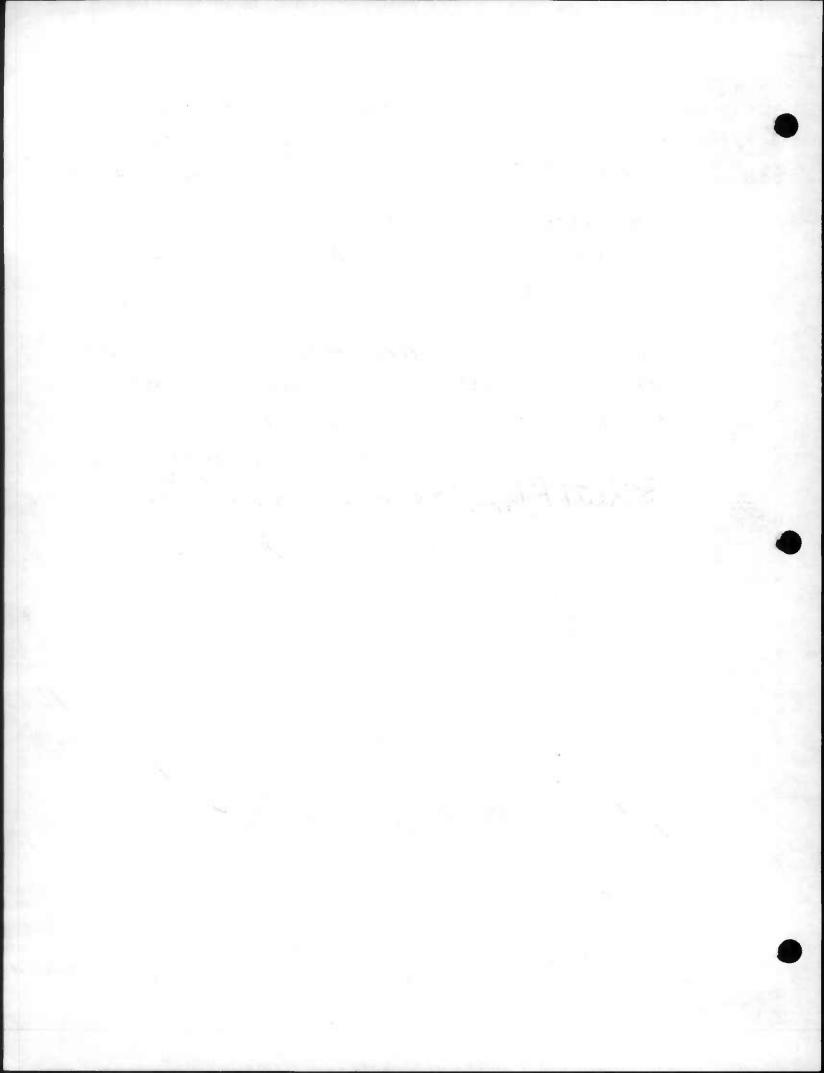
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	Amended #10b WCHD 4	/13/99 ead	Certificate of		Reg		1354
Physician /Medical	Becedent's Name (First, Middle, Last, BERNARD		WHITE		Date of Death Month April	Day Year 8, 1999	3. Time of Death 7:30 PM
Examiner	4a Facility Name (If not institution, give Salisbury Center,			4b. City, Town, or Local Salisbury	tion of Death	4c. County of Deeth	
Funeral Director	5. Social Security Number 6. Sec. 15. 32. 6. Sec. 15. 32. 75. 76. 15. 15. 15. 15. 15. 15. 15. 15. 15. 15		7 22 14 2 2 2 2	If Under 24 Hrs. 8. Hours Min.	Dete of Birth (Month, Day, Y)	(ear) 9. Birth	plece (State or Foreign intry)
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th with the Maryla 23s or 28e-f sho ust be notified at rai Director	10e. Street and Number 12489 LORRHA	Vertera	53	10g	. Citizen of What Cou	intry?	
urs after death ur, or thems 23 complex must by Funeral	11. Merital Status 1 Never Merried 2 Married 3 Widowed 4 Drivorced	2. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No 1 Yes, Give Year or Dates:	13. Wes Decedent of H If Yes, specify Cub	Hispanic Origin? (Specif an, Mexican, Puerto Ric Specify:	y Yas or No- an, etc.)	14. Race - Ameri Black, White Specify:	
ed within 72 horygiene. Ar then "natural, f., the Medical, Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16 completed) College (1-4or 5+)	Sa. Decedent's Usuel Occup (Give kind of work done life. DO NOT use retire	pation during most of working RUMER		b. Kind of Business/Ir	
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Artificate be executed ing physician and seas the burial-transit Medical Examiner Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	Due to (or as	a consequence of): A Consequence of): A Consequence of): B consequence of):	myrpross USIS	g.		Onset end Death
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es the igner be d	Drobates	Sufferely 2080	Sholse	<u>ې</u>	24a. Wes en o	autopsy 24b. V	Vere autopsy findings veilable prior to completion of cause
The page	25. Was case referred to medicat			26. Place of Death (1 Yes	1	f déath? ☐ Yes 2☐/No
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification	29e. Certifier 1 Certifying Phys	building, etc. (Specify) iclan: To the best of my knowled er: On the basis of examination	ge, death occurred at the ti	me, dete end place, end	City or Town, S	State)	stated.
To the To the comple	29b. Signeture and title of certifier	and manner stated.	29c. Licens			Date signed (Month	
State Registrar	30. Nema and eddress of person who co WATK 31. Date filed (Month, Day, Year) APR 1 3 1999	mpleted cause of death (ftem 23) MW 110 32 Registrar's Signatura		DR.,SALISBU	RY, MD.	21804	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 4 3 8 5

						Cei	tificate o	f Death	Re	g. No.	4 7 5	
	D1		1. Decedent's Nama (First, Middla, Las	t)					2. Data of Death		Yaar 3.	Tima of Death
Physici /Medio			WILLIAM C	LIFFORD		WEB	WEBSTER			APRIL 12,1999		0:56 PM
	Examir		4a. Facility Nama (If not institution, giva	straat and numbar)				4b. City, Town, or L	4	4c. County		
			9930 N. MAIN ST.					BERLIN		WOR	CESTER	
	Funeral Director		5. Social Sacurity Number 6. Sa	X 7. Ag X M 2□ F	ga (In yrs. Ia	st birthday) Yrs.	If Undar 1 Yas Months Day	ar If Undar 24 Hrs.	8. Data of Birth (Month, Day, FEB 13	Year)		(Stata or Foraign
	land ow	Usual Residance of Dacadant 10a. Stata 10b. County 10c. City, Town or Location										nsida City Limits
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	158.	Director	10e. Street and Number		10	On Citizen of I	Whet Country?					
	With With		9930 N. MAIN ST.				10f. Zip Code	1811		U.S.		
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5-0020	13-UUZU 172 hours after death with the Manyland "neturel", or Items 23s or 28s-f show adical Exercise Frust be notified at	by Funeral	1 ☐ Navar Marriad 2 🕱 Marriad 3 ☐ Widowed 4 ☐ Divorced	Armad Forcas? 1 X Yas 2 □ I If Yas, Giva Yaar or Datas:	No		f Yas, specify Cu 1 □ Yas 2 🕅 N	f Hispanic Origin? (Spuban, Maxican, Puarto o Spacify:	Rican, etc.)		ck, White, atc.	
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altimore,	gas 1 and it of Haalt if item 27 or other 1		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Neme of natory or other p	(laca)	Data 2	Oc. Location -	City or Town, S	Stata
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DIVISION	され 中 こ	Certification:	3 Suicida 6 Could not ba 4 Homicide datamined	28a. Place of Injubuilding, atd	ury - At hom c. (Specify)	na, farm, str	aet, factory, offic	е	28f, Location (Streat and Number or Rural Routa Number, City or Town, Stata)			
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	" x/n	-	30. Nema and address of parson who co	ompleted cause of d	aath (Item 2	23a) (Tyne	Print)		0	TII	-///	44
	10		CHARLES FOCASI	4 ADE.	Nh	540	RIVE	0759 RSIDE DA	SUTE G	5 SAL	15 BURY	MD 2/80/
		te	31. Data filad (Month, Day, Yaar)	32. Regiştra								



Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month. **Physician** Frances Daniels Werth Apr 1 1020 /Medical 4a Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Year) June 11, 1918 If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** Deys Months Hours 1 M 2 F Virginia 213-18-8036 Director Usual Rasidance of Decedent death with the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yas 2 ☐ No Maryland Washington Hagerstown Directo 10e. Sireel and Number 10f. Zip Coda 10g. Citizen of What Country? 18725 Briarwood Drive 21742 USA Funeral Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Ricen, atc.) 14. Race - Amarican Indian, 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No Black, Whita, atc. 2 should be filed within 72 hours after on and Mentel Hygiena. Is marked other than "natural", or item 1 Navar Married 2 Married If Yas, Give Yeer or Dalas: 1 ☐ Yas 2 No Specify: Specify. White þ 3 Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Cotlege (1-4or 5+) homemaker home 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) permit. Peges 1 and 2 should be f Department of Health end Mentel I Important: If Itam 27 Ia marked of any njury or other traumatic eve Lucille Walter Mckinley Daniels Rutland 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret D. Harper Sister 18725 Briarwood Drive Hagerstown, Maryland 21742 20b. Place of Disposition (Name of Deta 20c. Location - City or Town, Stete 20a. Mathod of Disposition Smithsburg Crematory 1 ☐ Burial 2 M Cremation 3 ☐ Ramoval from State 4/16/99 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Ligs 22. Nama and Addrass of Fecility Gerald N. Minnich 305 N. Potomac Street 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Maryland 21740

Approximate 501240**

Puneral Home Hagerstown, Maryland 21740

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Puneral Home Hagerstown, Maryland 21740

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Approximate 501 **Physician Cardiovascular desease 15 yrs Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Examiner physicien end s the burial-transil The law requires that the death certificete be executed Sequantially list conditions, if any, laading to immediata causa. Entar Undarfying Cause (Disease or injury thal initiated avants resulting In death) Last Dua to (or as e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai Dua to (or as e consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes No heart failure 3 Probably 4 Unknown þ 24b. Ware autopsy findings availabla prior to completion of ceusa of daath? 24a. Wes an autopsy performed? Completed peed 24 hours efter death. • Funeral Director: After this certificate has letely filled in by the funeral director, pege 2 20 No 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Was cesa rafarrad to medical axeminer? 26. Plece of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 25 No P 1 Inpaliani 2 ER/Outpatient 3 DOA 27. Mannar of Death 28b. Tima of Injury 28d. Describe how Injury occurred 28e. Deta of Injury (Month, Day Year) 28c. Injury at Work? Certification: 5 Panding invastigation 1 Yes 2 No 2 ☐ Accidant 6 Could not ba datarminad 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida Sertifying Phyaician: To the best of my knowladge, death occurred at the time, deta and place, end due to the causa(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the causa(s) and mannar stated. edical 29a. Certifie (Check only one) within 2 29b. Signature and tale of certifias 29c. Licansa number 30. Name and address of person fino completed ceusa of death (Item 23a) (Type-Print)
Dr Newman 11110 Medical (Climpus Road Hagerstown Maryland 32. Ragistrar's Signatura 31. Data filad (Month, Day, Year) State APR 1 5 1999 Registra

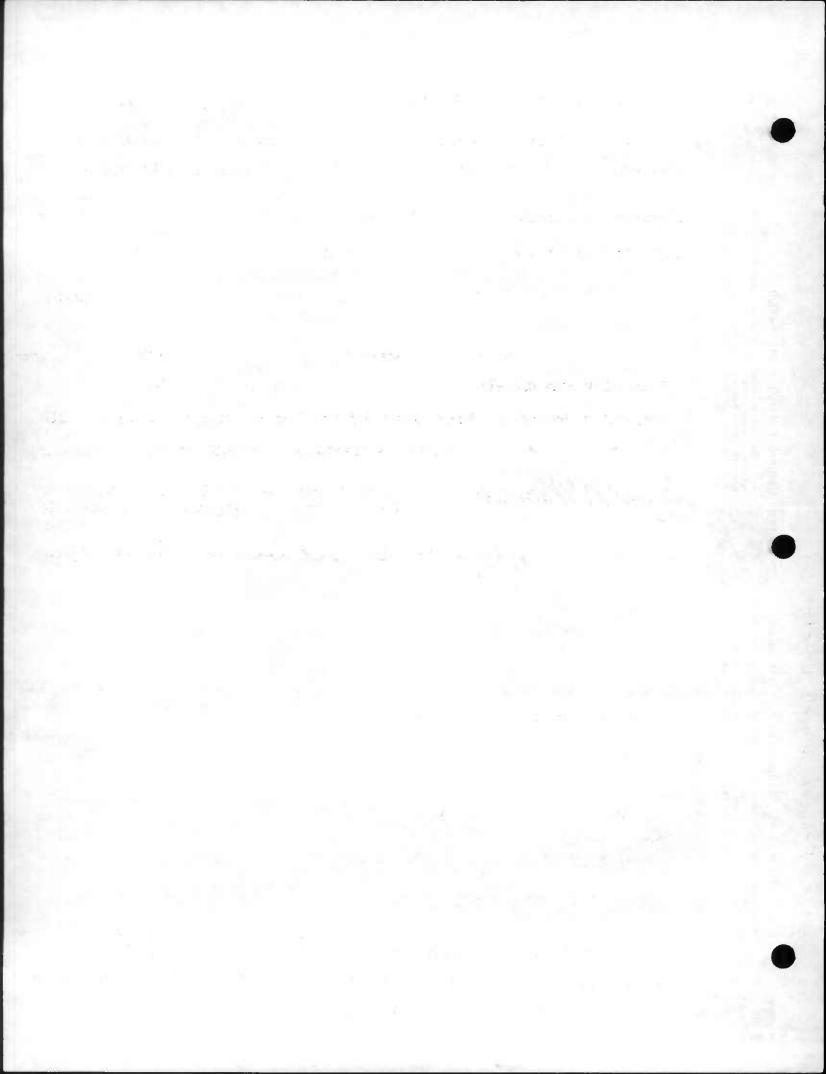
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State of Maryland / Department of Health and Mental Hygiene

DHMH 16 Ray 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					Ce	rtificate	of Death		Reg. No.				
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	/Medi	_	Helen 1	-1120eger	1 70	201	e	April	71	1999	9,00a1		
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						If Under 1		r Spring		ingto			
L	Funeral Director		5. Sociel Security Number 6. Sec. 2 20 ~/6~ 2957 Usuel Residence of Decedent	7. Age (In M 2 ☑ F	yrs lest birthdey) Yrs.		Deys Hours	Min. (Month, Di	27, 191	9. Birthplace Country) 7 PA.	e (Stete or Foreign		
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	tha 28a	Director	10e. Street end Number			10f. Zip (Code		10g. Citizen of W	/het Country	?		
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	death ms 2	Funeral	11. Marital Status	12. Wes Decedent Ever	in U,S. 13.	Wes Decede	nt of Hispenic Origi	n? (Specify Yes or No Puerto Rican, etc.)	o- 14. Race	- American			
215-0020	72 hours effer death with the Maryland naturel', or fterns 23a or 28a-f show gical Evantine must be notfred at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No if Yes, Give Yeer or Detes:		If Yes, specif		Puerto Rican, etc.)		k, White, etc. whit			
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Maryland	s 1 end 2 should be filed f Haeth and Mental Hygi Itam 27 is marked other other traumatic avent,	To Be (17. Fether's Name (First, Middle, Last) David Heckman					s Name (First, Middle ice Stone		e)			
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ore			20a. Method of Disposition	The state of the s	b. Plece of Dispo	sition (Neme	of er placa)	Dete	20c. Locetion - (City or Town	, Stete		
E	Peges nent of int: if its iry or o		15 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) St. Paul Cem. April 10,1999 Clear Spring,										
Baltimore	permit. Pege Depertment o Important: If i any injury or once.		21. Signature of Funerei Service Licanse		I	onal	Address of Facility d Edwin	Thompson	n Funer	al Ho	me,Inc		
r			23a, Pert1. Enter the disease, or complishock, or heert failure. List only or	cetions that daused the	death. Do not en	er the mode	of dving, such es c	Clear Spi	ring, MD	2172	2 oproximete		
18	Physician		shock, or heert failure. List only or	e ceuse on each line.						int	tervei Between nset end Death		
	/Medical	1	Immediate Cause (Final	Acut	e MV	Vacandil T. f tion 10 minus							
	Examiner	Immediate Cause (Final disease or condition resulting In death) a. Acute Myo condial Inforction Due to (or es a consequence of): Authoris (evotro Covonony Authory disease									Milleria		
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	icata be executed physician and s the burial-transit	Examiner	Sequentially list conditions.		to (or es e conse		ANT TO THE	1 410.	_ (~~ (- 1	V Jeers		
0,	e exe ian ar urial-t		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
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	To th To th comp	Me	29b. Signature end title of certifier	10 Da 1	DI.	29c.	License number	1250	29d. Date signed	(Month, Day	y, Year)		

of death (Item 23e) (Type, Print)

32. Registrar's Signeture

APR 0 9 1999

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene (Item#8 perFH G771 5/4/99 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Millicent S. Adcock 28 1999 0100 April /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A Date of Birth 3-22-22 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1□M 2♥F Yrs 217-18-0263 Director Maryland Usual Residence of Decedent with the Maryland il Hygiene, other than 'naturel', or itema 23a or 28a-f ahow vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits YY Yes 2□No Directo Maryland N/A Baltimore 10f. Zio Code 10g. Citizen of What Country? 10e. Street and Number 3838 Roland Avenue Apt 509 21211 death v USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Heelth and Mental Hygiene. important: If Item 27 ie marked other than "naturel", or heil eny Injury or other traumatic event, the Medical Examinat 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2√No Specify: Specify: White þ 3 ☐ Widowed 《 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Federal Reserve Bank 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Milton Seward Claggett 0 Lettie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21211 4422 Clydesdale Avenue Baltimore, Maryland 19a. Informant's Name/Relationship (Type, Print) Millie Bull Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 D Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/30/99 Pikesville, Maryland Druid Ridge Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Fecility Burgee-Henss-Seitz Funeral Home, Inc. 21211 a complete fions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory area. Mary 1 and Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final Colon Metastatic 9 months disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and s the buriei-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of): C.88 signed by the a d be detached f Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Records. 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to Completed completion of cause of death? page 2 : 1 Yes 2 No Attending Physician: Be 25. Was cese reterred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1월 Inpatient 2☐ ER/Outpatient 3☐ DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 1 MNatural 5 Pending investigation 1 Yes 2 No hours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) 4 T Homicide To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by edical 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contiller AU4176435K9260 April 28, 1999 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) MAY 0 4 1998

201 E. University Parkway Baltlmore, MD 21218 Erika N. Kane, 32. Registrar's Signature

MD

ORIGINAL

wir o 1 200 January & Aprilia

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month JAMES MC ALPINE mai City, Town, or Location of Death 4a Facility Neme (If not Institution, give street end number) County of Death Battimore Franklin Square 5. Social Security Number 6. Sex Hospital Oital Cent Age (In yrs. lest birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) If I Inder 24 Hrs. 8. Date of Birth (Month, Dey, Sept. 12 Hours MM 2□ F 218-12-5164 75 1923 Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☐ No Md. Baltimore Essex 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 1302 Sugarwood Circle 21221 IISA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Foreman Eastern Stainless 12th 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Alexander Ike McAlpine Anna Marie Hausrath 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Elizabeth McAlpine/wife 1302 Sugarwood Circle Baltimore Md. 21221 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the death. Donot enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one bause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final · Ischemic Cardiomyopathy disease or condition resulting in death) 10 years Coro Dary Artery Disease Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Reumonia, Diabetes Mellitus-II, Peripheral Vascular 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Disease with Dry Gangrene Right Foot, Paroxysmal Atrial Fibrillation, Hypertension 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending 1 ☐ Yes investigation 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

12 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated.

Division of Vital Records.

signed by the e or Attanding Physician: efter death. 24 hours e Hospital To the Hospi within 24 hou To the Funer completely fil

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f ahov the Medical Examiner must be notified at

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Registrar

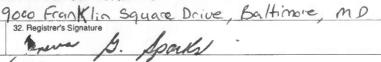
Medical

31. Date filed (Month, Dey, Yeer) 4 1999

29b. Signature and title of certifier

4 ☐ Homicide

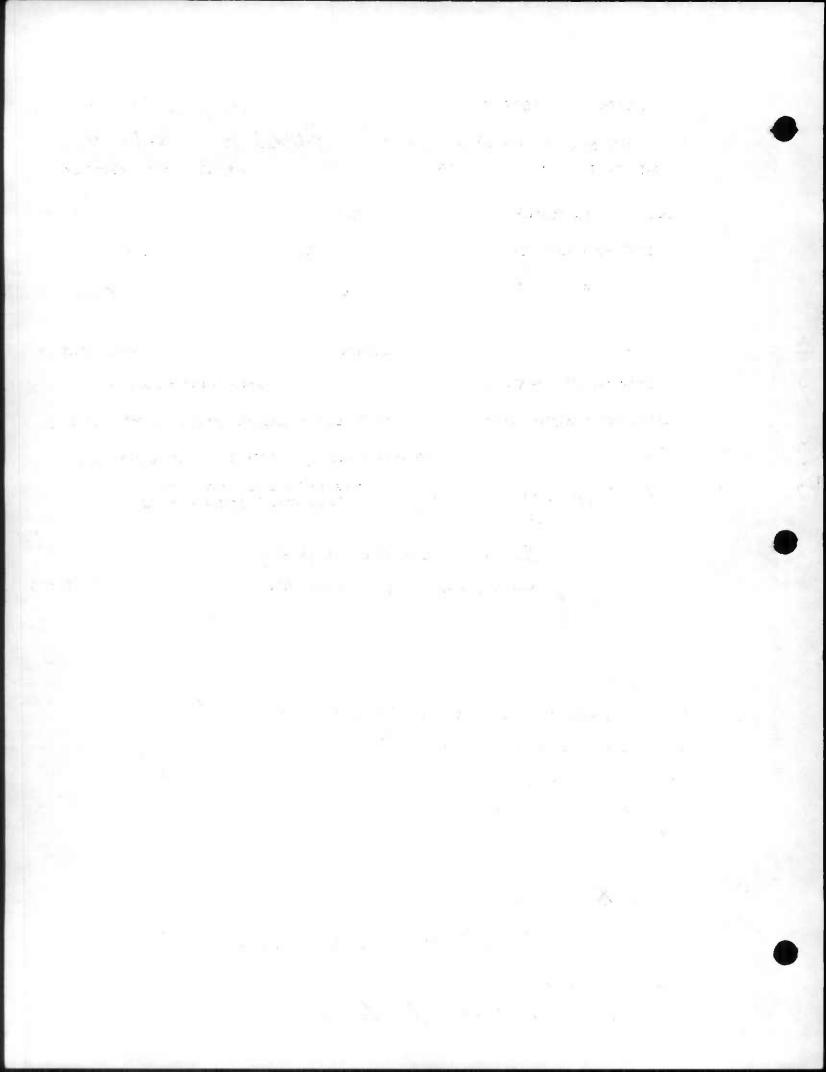
29a, Certifier



29d. Date signed (Month, Dey, Year) 29c. License number una a. Jus. A. Luchsinear, MD

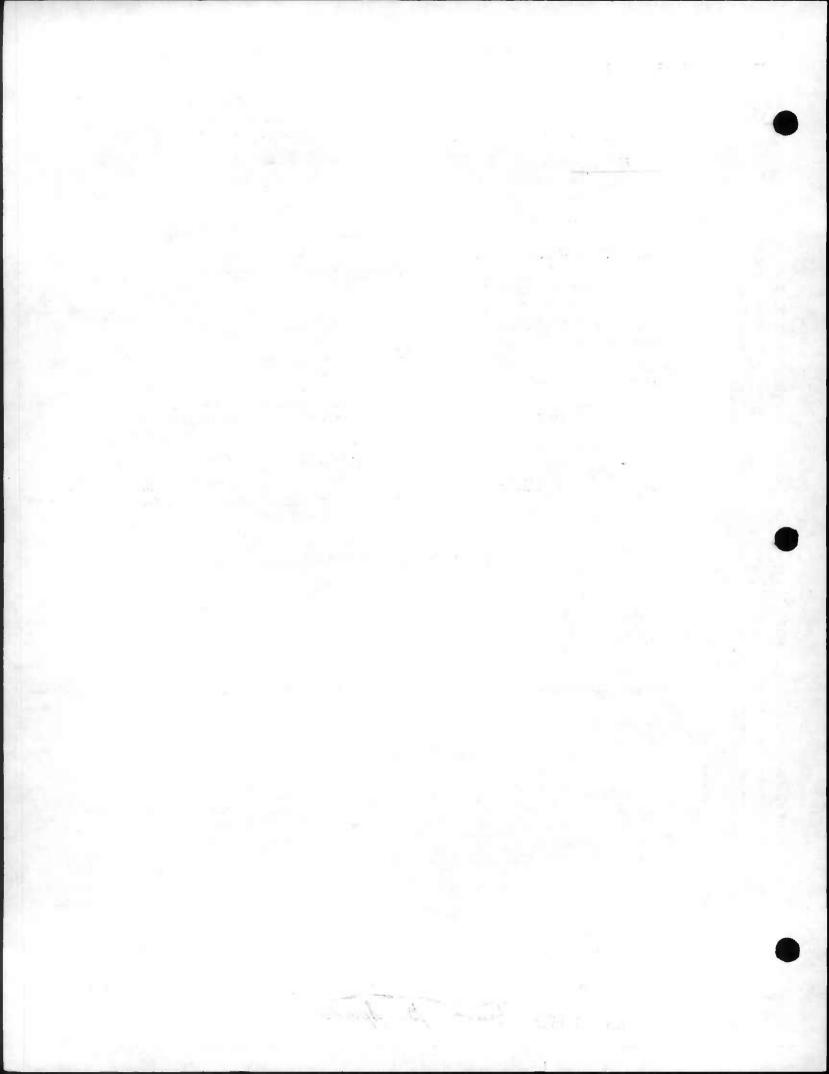
Dr. Joanne Luchsinger

30. Neme and eddress of person who completed cause of death (item 23a) (Type, Print)



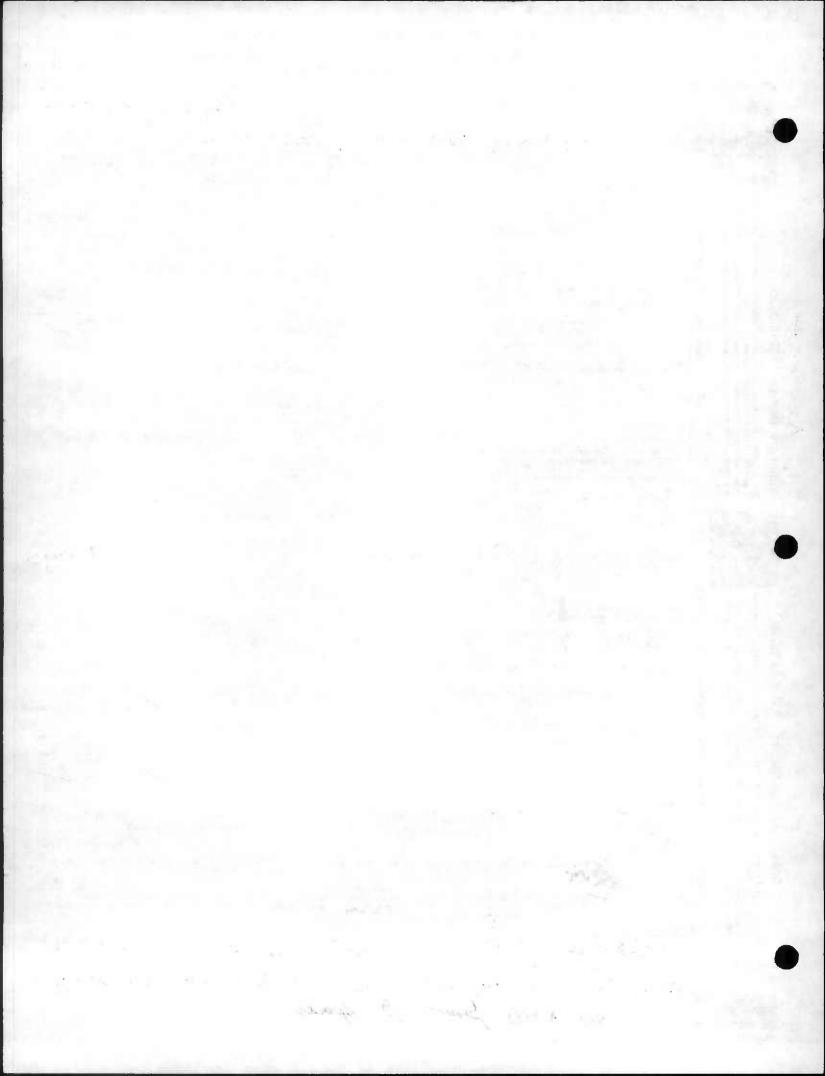
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ner		ive street and num	Location of Death 4c. County of Death										
			GHTS AVEN		. last birthday	/) If Under 1 Year	BALTIM If Under 24 Hrs.	ORE 8. Date of B	N/A	9 Righol	lace (State or Foreign		
	5. Social Security. 216-45-837	3461	10 M 20 F		7 Yrs.	Months Days		10723	OI ^{ar)}	Coun	laca (Stete or Foreign try) MD		
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Director	10e. Street and Nu					10f. Zip Code			10g. Citizen of	What Coun	try?		
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t	11. Marital Status		12. Wes Deced	dent Ever in U	J,S. 13	. Wes Decedent of	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or N	o- 14. Rac	e - America			
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	Elementary/Sec 12		College (1-	4or 5+)	HOUSE	DO NOT use retire	ed)	- dy	OWN F	HOME			
	17. Father's Name	(First, Middle, Las	st)				18. Mother's Nam	a (First, Middle					
2	SAMUE	L			SPI	EERT	YETTA		BE	CKER			
		lame/Relationship		AT.			t and Number or Rui						
-			RKOW / SO				OOD ROAD						
		•	Removel from S	tete	cemetery, cri	position (Nama of ematory or other ple RAEL_CEME		Date 5/3/99	BALTIM				
	21. Signature of F	uporal Service Lip	Grisiny 1		-	22. Neme end Addr	ess of Fecility						
	1/	10	097		8	SOOO RETS	SUI TERSTOWN I		SON & BE	-	INC. 1D 21208		
Be Completed by Physician/Medical Examiner	Sequentially list or if eny, leading to in cause. Enter Und Cause (Disease or that initiated event resulting in death)	5	c	Due to (or as a conse	equence of):							
	Pert tt. Other signi	ficant conditions	contributing to dea	th but not res	sulting in the	underlying cause g	iven in Pert I.	23b. Dio	tobacco use co	ntributs to	the cause of death?		
								1	Yes 2 No	3 Prob	ably 4 Unknown		
									s an autopsy lormed?	COF	ora autopsy tindings ailable prior to appletion of cause		
								45	Yas 20 No		death?		
1	25. Wes case refe	rred to medicat					26. Place of Dea			1	Yes 2□ No		
	axaminer?	/	Hospital:	patient 2] ER/Outpatie	ent 3 DOA O	her	1	onej sidence 6 □Ott	ner (Snacih	()		
	27. Manner of Dea 1 Neturat 2 Accident 3 Suicide 4 Homicide	th 5 Pending investigati 6 Could not determine	28a. Data of (Month) on be 28e. Piece of	Injury , Day Year)	28b. Time tnjury	of 28c. Inju	ork? Yes 2 No	28d. Describe	how injury occur (Street and Numi wn, Stata)	rred			
edical Certification: To	29a, Certifier (Check only one)	1 Certifying P	thysician: To the barminer: On the bas	ils of examine	owledga, dea etion end/or i	th occurred et the t nvestigation, in my	ime, date end place, opinion, death occur	end due to the	cause(s) and m	anner es st and due to	eted. the cause(s)		
	29b. Signeture and	title of cortifier	Will Hill	5.5.00		29c. Licen	se number		29d. Date signe	d (Month, I	Day, Year)		
	•	CM an	nmin.			D	42561		5/2	199			
9		ress of person who	completed causa			ds Drive	#400 0	wings A	nills, MD	211	17		



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 14391 Certificate of Death Reg. No.

						Certifica	ite of	Death			Reg. No.		105	
ysician	1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month Day										Yaar	3. Tima of		
Medical	ALEX							BERGER			02	1999	012	.0
caminer	4a Facility Nama (If not institution, giv	tal ef	0 -	ltir	neva		Bat	hm	cation of Death	4c. Cou	nty of Death	N/A	
ector	5. Social Security N	-0135	Sax IXIM 2□F	7. Aga (In yrs	last birth	Month	ar 1 Yaar s Days		24 Hrs. Min.	8. Data of Bir (Month, Da SEP . 4	th ly, Year) 1,1920	9. Birth Cou	placa (Stata o ntry) MD	r Foraign
100	Usual Rasidance of Dacadant 10a. Stata 10b. County 10c. City, Town or Location										10d. Insida Ci			
se notified at Director	MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of W									of What Cou		2 (3 140		
el Di	720 KA	HN DRIVE						2120	80		U.S.	Α.		
by Fur	11. Marital Status 1 □ Navar Marr 3 □ Widowed	rled 2 Married 4 Divorced	12. Was Dece Armad Fo 1 🖺 Yas If Yas, Giv Yaar or D	2□No N	J,S. AVY			Hispanic Ori ban, Maxicen Specify:	gin? (Spa n, Puarto I	acify Yas or No Ricen, atc.)		lace - Aman liack, Whita, cify:		re
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r tras		BERGER /								IMORE,			,	
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open and the control of the control	21. Signatura of Fu	the disaasa, or comart failura. List only	nsaa	eusad tha daa		22. Nama 8900	and Add	ass of Facilit	SOL OWN 1	LEVINS	SON & E	BROS.,	INC.	ween
tical iner	Immediata Causa disaasa or condition rasulting in daath)	on	a. Pr	Dua to		ia onsequance o	f):						7 da	45
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d be deteched for use					-					10	Yes 25 N	o 3□Pro	obabiy 4	Unknown
2 should	N- 7	113								24a. Was	an autopsy ormad?	a	Vara autopsy t vallabla prior t omplation of d f death?	0
Con											Yas 25N	1	☐ Yas 2 ☐	No
To Be Com	25. Was cesa refai axaminar? 1 ☐ Yas 2 ☑	_	Hospital:	Inpatiant 2	∃ER/Outr	patient 3 1	DOA O	thar:		n <i>(Chack only</i> ma 5□ Ras		Other (Spec	itv)	
funeral fon:	27. Manner of Deel		28e. Data (Mon	of Injury th, Day Yaar)	28b. Ti		28c. Inj			28d. Dascribe			ify)	
completely filled in by the funera Medical Certification:	2 Accident invastigation 3 Sulcide 6 Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)						•		28f. Location (Street and Number or Rural Route Number, City or Town, Stata)				nber,	
Medical C	29a. Cartifiar (Check only one)	12 Certifying Pt	niner: On tha ba											s)
Ме	29b. Signatura and	titla of certifiar	the	95				nsa number	N/Q!	95	29d. Data si			
5	30. Name and eddi	11.	completed ceus	sa of death (Ite		ype, Print)	7040	1000	R	95 Utm	N. V	un'	2121<	-
	David	oth, Day, Yaar	an 2	lagistar's Sign		IVER	W.C.	The.	130	~7.17	CVZ	10	-13	



signed by the t Completed certificate Be 2 this funeral

After

3

edical

or Attending effer death. Director: Aft

To the Hospital or within 24 hours aft To the Funerel Di completely filled in

à

Records.

of Vital

Division

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

NARCOTIC INTOXICATION 25. Was case referred to medical 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 2 17 No 1 Dres 2 No

3. Time of Death

4:52 A

Mes 2□No

Approximate Interval Between Onset and Death

examinar? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

investigation 6XXX Could not be determined

28a. Date of Injury (Month, Day Year) 4-30-99

Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 28b. Time of Injun 4:03

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

UNKNOWN

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 2921 MONTEBELLO TERRACE

29a. Certifier

31 Date filed

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) APRIL 30, 1999

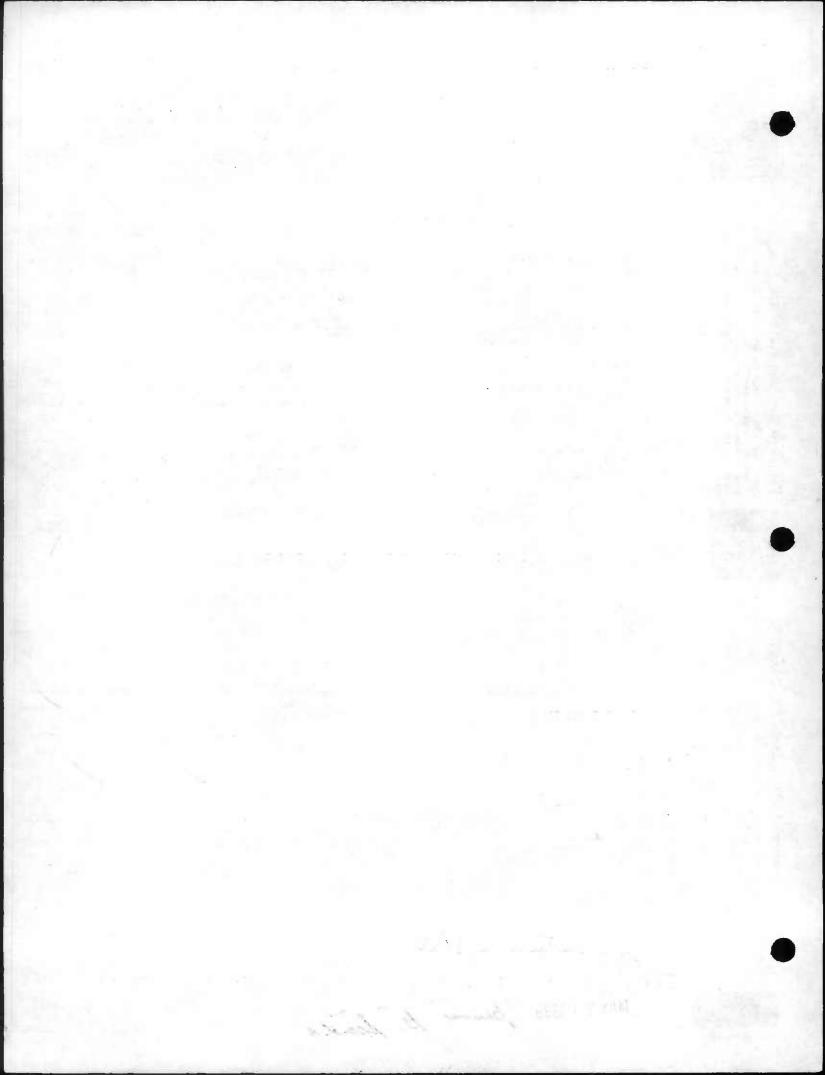
mpleted cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

tanel 32. Registrar's Signature

poor st. a



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month **Physician** Virginia 21:53 Burns Apri /Medical 4b. City, Town, or Location of Deeth 4e Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Baltimore Hopkins Bayview Medical | CENTER | During | Hours | Min. | Aug. 23, 1919 Lenter Johns N/A 5. Social Sacurity Number 6. Sax 7. Age (In yrs. lest birthday) Birthplaca (State or Foreign Country) **Funeral** 1 M 2 KF 79 Virginia 216-24-1234 Director Usual Rasidance of Decedant the Marylenc 10a State 10c. City. Town or Location 10b County 10d. Insida City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at Baltimore Dundalk 1 ☐ Yas 2 No Maryland Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21222 United States 7301 Martelle Avenue Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ĀNo If Yas, Giva Yaer or Dates; Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 □ Naver Marriad 2 □ Married Specify: White altimore, Maryland 21215-0020 1 □ Vas XX No Specify þ 3 NWidowad 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Hygiane. Elamantery/Secondary (0-12) Collega (1-4or 5+) 12 years Housewife Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Peges 1 and 2 should be fill ment of Haalth end Mantel Hy amt: If item 27 Is marked oth Be Clatie Acre Herman Call 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Bonnie Colville (Daughter) 241 St. Helena Avenue Baltimore, Maryland 21222 other 20a. Mathod of Disposition 20b. Piece of Disposition (Nama of cematery, crematory or other placa) 20c. Location - City or Town, Stete Data 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Department o important: If i eny injury or 0 Loudon Park Cemetery 5/3/99 Baltimore, Maryland 5 Othar (Specify) 21. Signature Funaral Service License 22. Nama and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 to the discuss, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or raspiratory errast, the first failure. List only one ceusa on aech line. Approximete Intarval Between Onsat and Death **Physician** /Medical Immediate Ceuse (Final Enterococcal 5 days 3eps15 disease or condition rasulting in death) Examiner Examiner Vancomycin-resistant Enterococcus urosepsis **buriel-transit** requires that the deeth certificate be executed Sequantially list conditions, if any, leading to immediate cause. Entar Undarlying Causa (Disaasa or Injury that initiated events rasulting in daath) Last Dua to (or as a consequence of) end Division of Vital Records, P.O. Box 68760 physician Physician/Medical the Dua to (or as a consequence of) 98 USB ö Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. ed by the dateched 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown multifocal atnal tachycardia signed i ρ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? tailure respiratory completion of ceusa of death? disease obstructive Dulmoha14 Chronic 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certifica 25. Wes case referred to medical axaminar? Be 26. Piece of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 2 Inpatiant 2 ER/Outpetient 3 DOA funeral 28c. Injury at Work? Certification: 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how Injury occurred 5 Panding Invastigation 1 Natural 1 Yas 2 No 2 Accidant 6 Could not be detarmined To the Hospital or Atterview within 24 hours after de To the Funeral Directo complataly filled in by the 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, straet, factory, office building, atc. (Specify) 4 | Homicide 1 Certifying Physicien: To tha best of my knowledga, daath occurred at the time, date and piece, end dua to the ceusa(s) and mannar as stated.

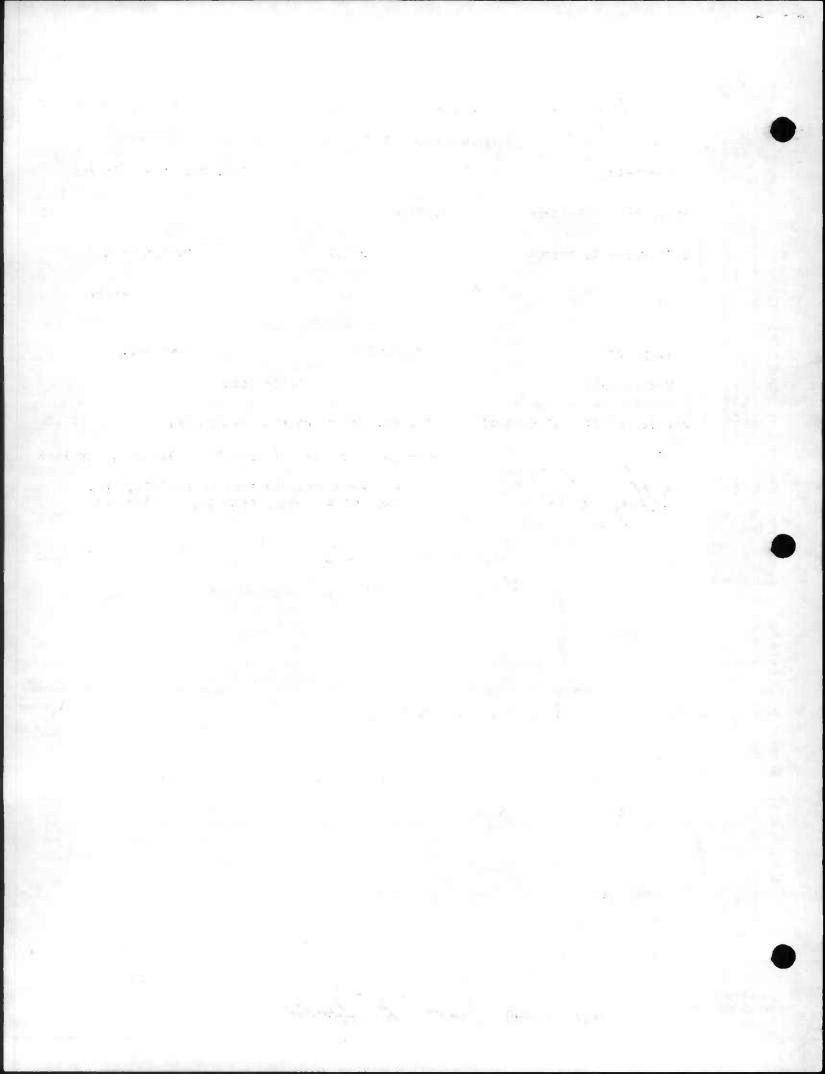
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, deta end place, and dua to the ceusa(s) and mennar statad. edical 29a. Cartifiar (Check only one) 29b. Signetyne end title of certifiar 29c. License number 29d. Date signed (Month, Dey, Year) my 30. Name and address of parson who complated cause of death (Item 23e) (Type, Print) Bayview Medical Center, Battimore Dankwa HOPKINS

446

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Day, Year)

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth Dey Beadenkapt DOROTHER 30 4e Fecility Neme (If not institution, give street end number) Town, or Location of Deeth 4c. County of Death Baltimore Bon Secours Hospital If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 1□ M 2□ F Months Days 80 Yrs. 220-05-0422 SEP. 27, 1918 Mary land Usuel Residence of Decedant 10c. City, Town or Location 10d. tnside City Limits 10a Steta 10b County 1 XYes 2 No Baltimore MD N/A 10a. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 21223 USA 1905 W. Lombard St. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ (No Specify: white Specify. 3 ☐Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlega (1-4or 5+) Own Home Housewife 9 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Annie Huttenberger George Herold 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) 19a. Informent's Neme/Reletionship (Type, Print) 1905 W. Lombard St., Baltimore, Md. Gloria J. Beadenkopf - daughter 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 5/03/99 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 4 Donetion 5 Dother (Specify) U.S. National@Loudon Pk. Baltimore, Md. 22. Name and Address of Fecility 21. Signalus of Funeral Service Lie Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 250 Washington Blvd., Elkridge, Md.

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line. 21075 Approximete Intervel Between Onset end Deeth Immediate Cause (Final · ASPIRATION disease or condition resulting in deeth) BSTRUCTIVED

Due to (or es e consequence of): Sequentially tist conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disaase or injury that initieted events resulting in death) Lest DISBASE Part II. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were eutopsy findings aveitable prior to completion of cause of deeth? 24a. Wes en eutopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was casa raferred to medicel exeminer? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28a. Dete of Injury (Month, Dey Yeer) 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Time of 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 3 Suicide Location (Straet end Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homloide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end menner stated.

The law requires that the death certificate be executed Box 68760. Division of Vital Records, P.O.

physician er s the buriel-t signed by the a peen pege 2 certificata al or Attending Physician: T s after death. If Director: After this certilicat ed in by the luneral director, p To the Hospital or within 24 hours aft To the Funeral Di complataly filled in

Physician

/Medical

Director

Funeral

λq

Examiner

Funeral

Director

death with the Meryland

permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryla Department of Health and Mantal Hygiane. Important: If Item 27 is merked other than "natural", or items 23e or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified an once.

Physician /Medical

Examiner

Examiner

Physician/Medical

Àq

Completed

Be

Certification: To

edical

29a. Cartifiar (Check only one)

29b. Signature end title of certifier

MAY

Baltimore, Maryland 21215-0020

State Registrar

0/0-BON SECOUR 31. Data filad (Month, Dey, Year) 4 1999

DR. EFEM IMOKE 30. Name end eddress of person who completed cause of coath (Itam 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Dev. Year)

BALT.

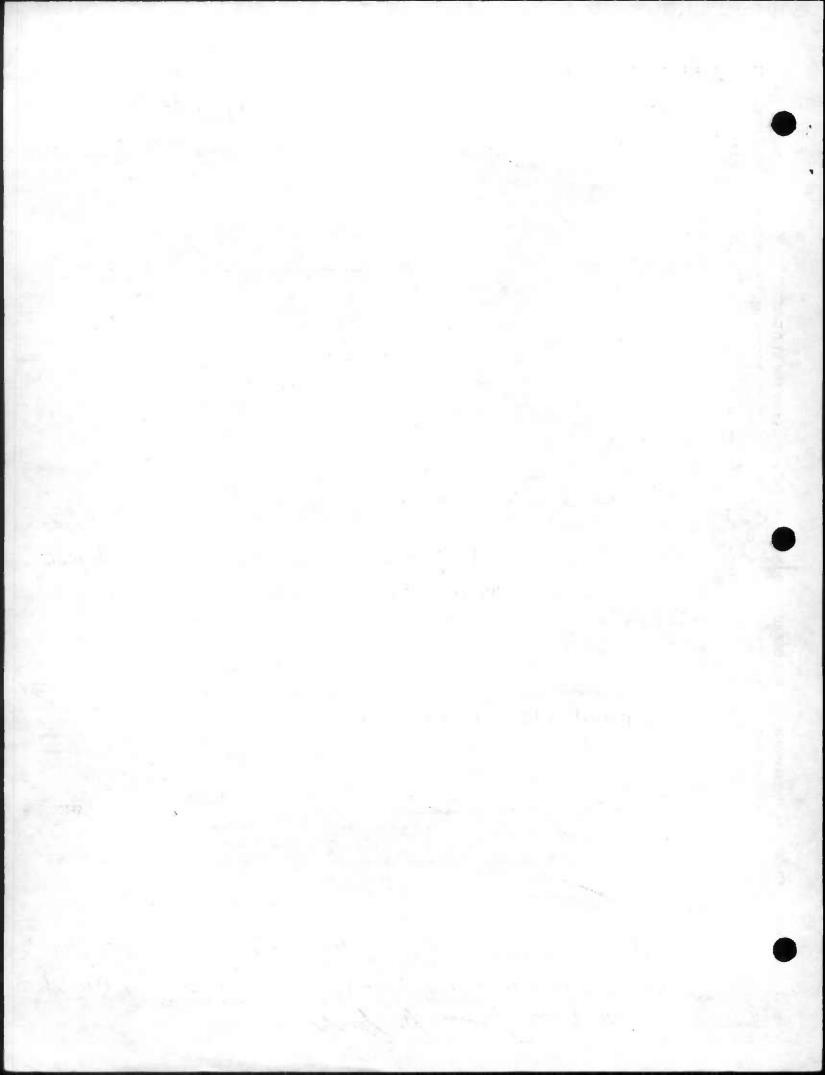
32 Registrer's Signeture

was and the second

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 4 3 9 5 State of Maryland / Department of Health and Mental Hygiene

ITEM: #26	PER MD G771 5-4-99 WR.	Certificate of Death	Reg. No.					
Physician /Medical	1. Decedent Name (First, Middle, Last) AXINE AVTIS	th Ch. Taus or	Horil 28, 19	3. Time of Death 7:05 p. m				
Examiner	49 Facility Nama (If not institution, give street and number) 1450 Watts Ave.	4b. Cny, Town, or Sever	Location of Death 4c. County of I					
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last 1 M 2 F 49		8. Date of Birth 9.	Birthplece (Steta or Foreign County) (ary Land				
pu &	Usuet Residence of Decedent 10a. State 10b. County 10c. City, 7	Town or Location		10d. Inside City Limits				
the Marylan 28a-f show floured at	Maryland None	Baltimore		1 No Yes 2 No				
E 9 8		10f. Zip Code 21215	10g. Citizen of Wha	SA				
O she w	11. Marital Status 12. Wes Decedent Evar in U,S. Armed Forces? 1 Never Merried 2 Merried 1 Yas 2 No	13. Was Decedent of Hispanic Origin? (5 ff Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	Canaih:	American Indien, White, etc. Black				
1 21215-002 led within 72 hours organizations. National contractions of the transfer of the tr	15. Decedent's Education (Specify only highest grede completed)	6a. Decedent's Usual Occupation (Giva kind of work done during most of wo	rking 16b. Kind of Busin	ess/industry				
d within giene.	Elementery/Secondary (0-12) College (1-4or 5+)							
and 2 be filed tal Hygind other event, the	12 H. 17. Fathar's Name (First, Middle, Last) Unknown	ome Health Care Aid 18. Mother's Na Betty	Private H me (First, Middle, Meiden Sumeme) Artis	omes				
Marylan d 2 should be th and Mental 7 le merked drumatic ev		19b. Meiling Address (Street and Number or R		ite, Zip Code)				
Me and 2 and 2 is 127 le	Denise Johnson / Niece	3826 Kilburn Rd. Rand	allstown, Marylan	d 21133				
Battimore, Nomit: Pages I and Department of Health Important: If Heat 27 eny Injury or other trans.	142 burial 2 U Cremetion 3 U Removal from Stete	e of Disposition (Neme of etery, cremetory or other plece) ing Park	Date 20c. Location - City 5-1-99 Woodlawn,	y or Town, State Maryland				
Baltim permit. Pa Departman Important: eny Injury price.	Signature of Funerel Service Licensee	22. Name end Address of Fecility The Derrick C. Jon 4611 Park Heights		Jaryland 21215				
certificate be executed noting physician and use as the burial-fransit	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in dealth) Last	s e consequence of): (1 +1 C C AN CRY s a consequence of): (a consequence of):		year .				
O. Box se death oer the attendin hed for use	Pert II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Pert I.	23b. Did tobacco use contril	bute to the cause of death?				
O the part of	Right pleural ef	Right pleural effusion						
cord requir been s should			performed?	4b. Were eutopsy findings available prior to completion of cause of deeth?				
of Vital Re- hystelen: The law bits certificate has al director, page 2.	25. Was case referred to medical	26. Place of De	1 ☐ Yes 2 ☑ No eth (Check only one)	1 Yes 2 No				
of Vita Physician: this carific ral director	examiner? 1 Yes 2 No Hospitel: 1 Inpatient 2 ER		fome 5 ☐ Residence eXÓOther ((Specify) HOSPICE				
After Huner	1 Matural 5 Pending (Month, Dey Year) 2 ☐ Accident investigation	Ib. Time of Injury et Work? M 28c. Injury et Work? 1 \[\text{Yes} 2 \] No	28d. Describe how injury occurred					
DIVISI tal or Atten in after deat wil Director: led in by the Certifica	3 Suicide 4 Homicide 4 Homicide 4 Could not be determined 28e. Plece of Injury - At home building, etc. (Specify)	e, ferm, street, factory, offica	28f. Location (Street end Number of City or Town, State)	or Rural Routa Number,				
Div To the Hospital or a within 24 hours after To the Funeral Dire completely filled in b	(Check only one) 12 Certifying Physician: To the best of my knowledge (Check only one) 12 Medical Examiner: On the basis of examination and menner steted.	end/or investigation, in my opinion, deeth occ	urred et the time, date end plece, and	due to the cause(s)				
To T or M	29b. Signature and the black of the selfect of the self of the sel	lane H4824	7 April 3	29,1999				
State Registrar		o East Fayetle S	treet, Battimon	e Maryland				
DHMH 16 Rsv 6/95	MAY 4 1999 Jeneva	D. Sparks						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 1999 BRADWAY ELSIE 5 MAY 1:27 AM 01 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number, 4c. County of Death 6000 SAMARITAN HOSPITAL BALTI MORE. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 F Yrs. 182-10-7470 APR 16. 1908 Pennsylvania Usual Residence of Decedent 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Y☐ Yes 2☐ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5628 Woodmont Avenue 21239 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: White Specify: Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nonprofit Bookkeeper/Secretary Organization 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Schweitzer Kathryn Bergey 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn S. Ulmer/sister 623 Fountain St. Philadelphia, PA 19128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 05/04/99 Baltimore, MD 21. Signature of Furieral Service Licensee 22 Name and Address of Facility Cremation Society of Maryland, Inc. AMCDonald 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VENTRICULAR ARRYTHMIAS 1 DAY Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Dfd tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homleide

Examiner physician end s the buriel-transit requires that the death certificate be executed 98 980 certificate has b director, page 2 s Attanding Physician: funerel or Attano after deat Director:

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Manyland ment of Heelih and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or items 23s or 28s-f ahow ury or other than the Mental Excition matter exciting any or other traumatic event, the Medical Excition matter exciting a

permit. Page Department of Important: If any Injury or

Physician

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Physician/Medical Examiner

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Completed

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Certification: To

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altimore, Maryland 21215-0020

P.O. Box 68760, Division of Vital Records, 24 hours after Funeral Directletely filled in b

To the I within 2

31. Date filed (Month, Day, Year) State MAY Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

Anchin

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) MATH NONA 32. Registrer's Signature 1999

da MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and manner as stated.

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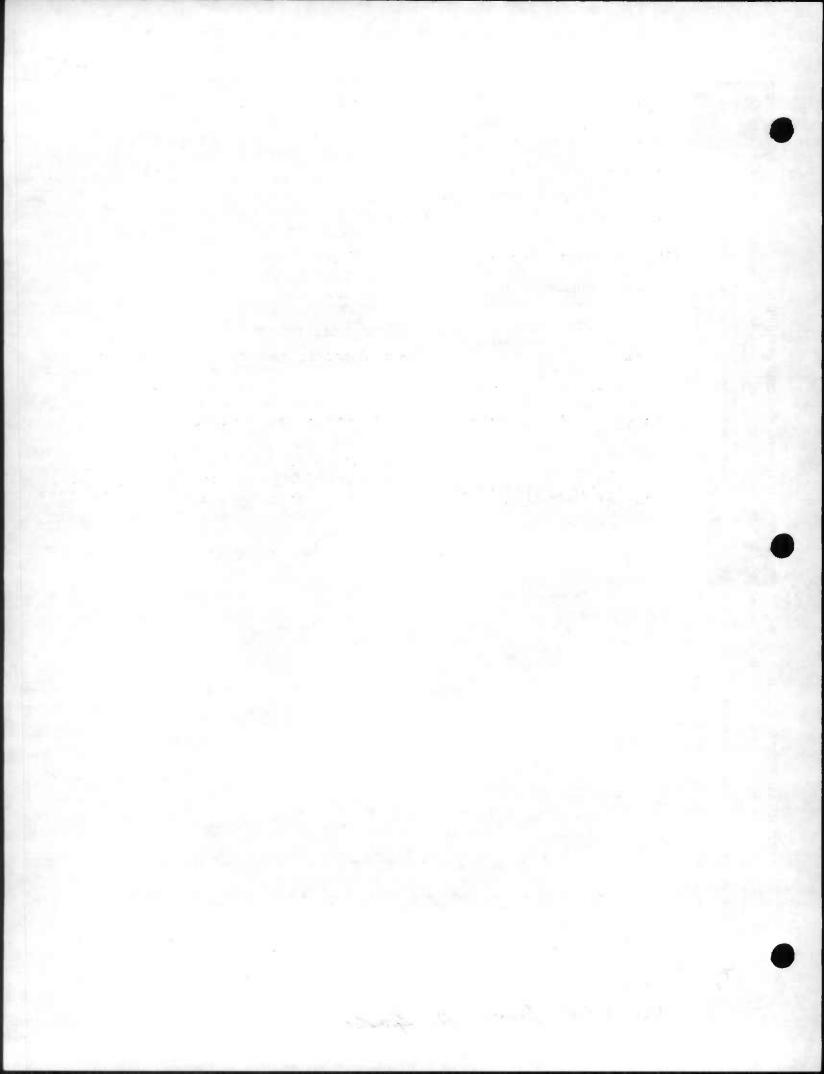
29c. License number

P-12562

29d. Date signed (Month, Dey, Year)

SAMARITAN HESPIAM BATIMONE

MAY 01, 1999



State Registrar end

DHMH 16 Ray 6/95

111 Penn Street, Baltimore, Maryland 21201

completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signature

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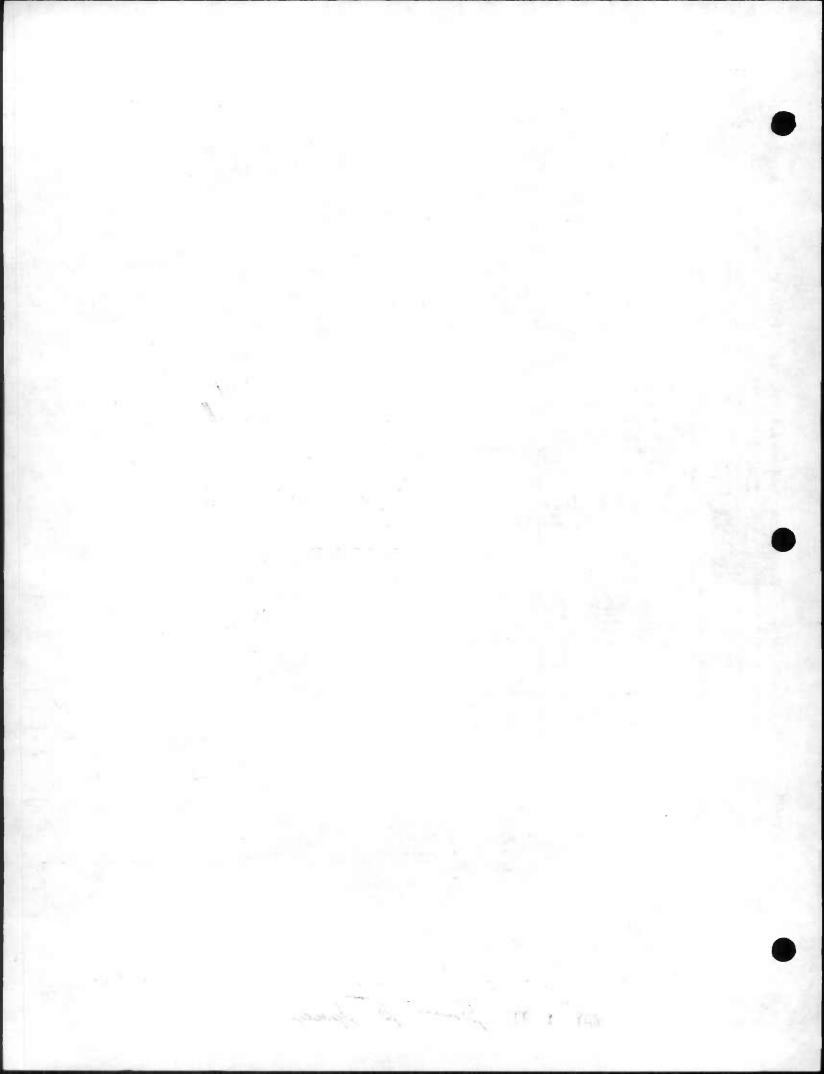
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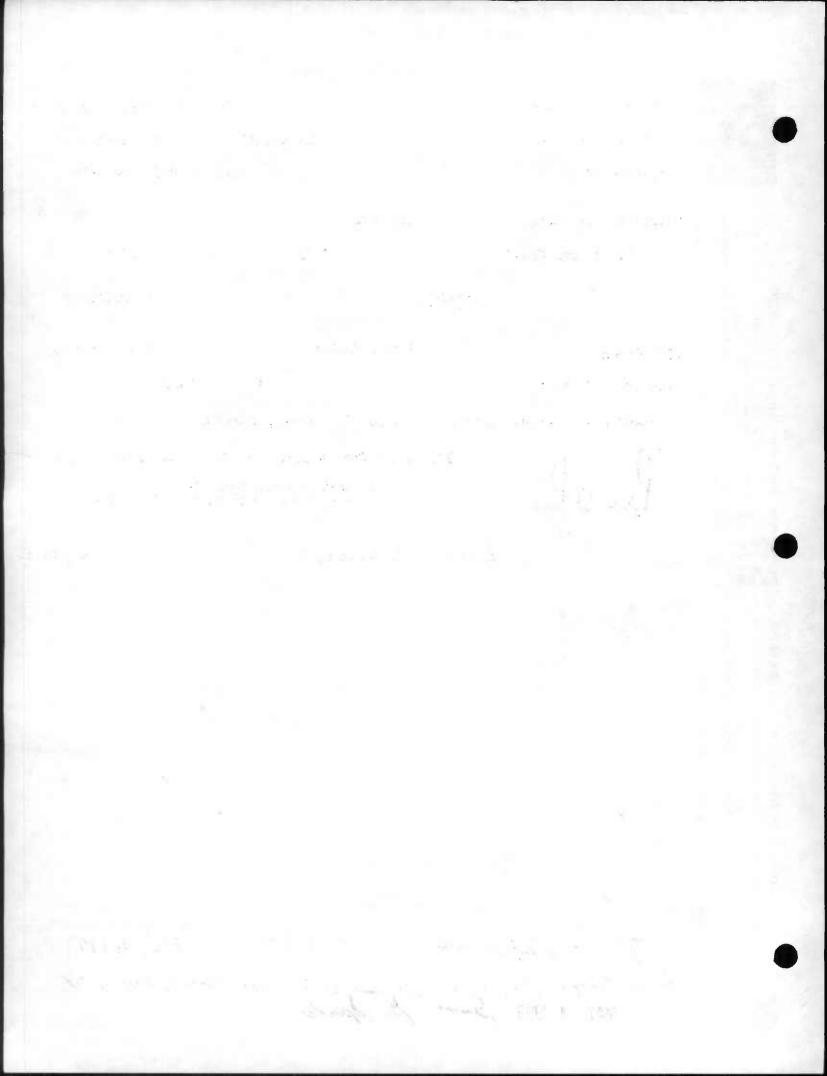
OHN OLE ITEMS:	#23 PART I, 27, 28A-F PE	State of Marylan	99 WR Certific	ate of	Death		Reg. No.	143	
Physician	1. Decedent's Name (First, Middle, Las	1)				Month	Month Dey Year		3. Time of Death
/Medica	JUHN EDWARD COLE	etreat and number)			th City Town o	APRIL Location of Deat	APRIL 30, 1999 08:29 A		
Examiner	1218 APPLELEAF C				BALTIMO		N/A	or Dodair	
Funeral Director	5. Social Security Number 6. Se	-	(. last birthday) If Ui Mon	nder 1 Year ths Days	If Under 24 Hr. Hours Mir		rth	9. Birthplac Country MARY L	e (State or Foreign
	Usual Residence of Decedent								
arylar show id at	10s. State 10b. County		ity, Town or Location					10d.	Inside City Limits 1 ☐ Yes 2 ☑ No
or 28s-f	PA. YORK	SI	EWARTSTOW	. Zio Code		I	10g. Citizen of V	Affact Country	
23s or unithe							U.S.A.		
urs after des	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in a Armed Forces? 1 💢 Yes 2 No If Yes, Give Year or Dates: 198	ff Yes,	ecedent of H specify Cubs	ispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)		e - American ck, White, atc.	
od within 72 ho ygjene. er than matur f, fo	15. Decedent's Ed (Specify only highest grad	ication le completed)	16a. Decedent's (Give kind or	work done of	during most of we	orking	16b. Kind of Bu	usiness/Indus	try
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a 2 should be file end Mentel Hy I te merked oth reumands event					CAROLE	JOHNSON			
s ahould end Men emarke emarke	19a, Informant's Name/Relationship (7	ype, Print)	19b. Meiling Add	ress (Street	and Number or F	Rural Route Numb	oer, City or Town,	State, Zip Co	ode)
* 5 5 6 F	INGA COLE (WIFE)	- Ion			EET, ST	EWARTSTO		17363	
aemit. Pages 1: Separtment of He reportant: If Item my Injury or oth sign.	20a. Method of Disposition 1 🔯 Bugial 2 Communication 3 🗆	Removel from State	Plece of Disposition cemetery, crematory	or other pled		Dete	20c. Location -		
ortent ortent injury	4 Denation 5 Other (Specify) 21. Signature of Funeral Service Libera		VET CEM. AT	GARRI:		T 5/4/99	OWINGS	MILLS,	, MD.
Depart Inpo	1 h- D		SCHI	MUNEK	FUNERAL	HOME OF		, INC.	
Physician /Medical Examiner	23a. Part1 Enter the disease of comp shock, or heart faller. In only composite Cause (Final disease or condition resulting in death)	ALCOHOL AN	D NARCOTIC I	NTOXICA		ac or respiratory a	arrest,	Int	pproximeta terval Between nset and Death
te be executed by sicion and the burlet-transit		b. Due to (or es e consequence of):							
the physical property of the physical property	resulting in death) Last	Due to (or es e consequence	of):	<u> </u>				
desth d for	Part II. Other significant conditions co	ntributing to death but not re	sulting in the underlyi	no cause oiv	en in Pert I.	23b. Did	tobacco use co	ntribute to th	ne cause of death?
		art II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.					Yes 2□ No		. 1
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F # 2 0						1/8	Ses 2□No	15th	(as 2□ No
certificate irector, pag	examiner?	Hospital:		Oth	00	eeth (Check only	**		
4 5 F	ILAYes 2 No	28a. Date of Injury 28b. Time of a 28c. Injury et					tome 5 ☐ Residence 6 🖾 Other (Specify) 28d. Describe how injury occurred		
th. After	1 Natural 5 Pending 2 Accident investigation	Found: Month, Day Year) Found: M 1 Yes 2000					UNKNOWN		
lal or Attending P is effector: After tell in by the funerical Cartification:	3 Suicide 6 Could not ba 4 Homicide determined	4-30-99 8:15						loute Number. LEAF CI.	
Hospi 4 hour Funer tely fill	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deeth occur						
Within 2 to the comple	29b. Signature and title of certifier	11.		29c. Licans	e number	29d. Date signed (Month, Day, Year)			
	Merri (Musero		OCM	Œ		MAY 01,	1999	
	Dennis J Ch	ompleted cause of death (Ite	111 Pen	n Stre	et, Bal	timore,	Maryland	21201	L
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	eture &.	Loo	els!				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Raymond S. Citrano May 1999 3:40 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner 2 F Brook Farm Court Perry Hall Baltimore If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year Birthplaca (Stete or Foreign Country) 7. Age (In vrs. lest birthday) **Funeral** 1 M 2□ F Months Davs 70 Yrs. 214-22-4477 Aug. 8, 1928 Maryland Director Usual Residence of Deceden with the Maryland 10c. City, Town or Location 10d. fnside City Limits 10e Stete 10h County must be notified at 1 Yes 2 No Baltimore Directo Maruland Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2 F Brook Farm Court 21128 Funeral Pages 1 and 2 should be filed within 72 hours after death tent of Haalth and Mental Hygiens. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No hean Yes, Give Yorkan Year or Date Onflict *natural*, or items ? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 7 is marked other than "natur traumatic event, the Medical 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker U.S. Postal Service 12th Grade 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Vincent Citrano Sarah Pitarra 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Haath ar Important: if item 27 is eny injury or other trau ance. Antoinette G. Citrano (wife) 2F Brook Farm Court, Perry Hall, MD 20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Byrial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Joseph Church Cem. 5/5/99 Baltimore. Maryland 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21, Signatu of Funeral Servica 9705 Belair Rd., Baltimore, MD 21236 sins 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. Light quiy one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical d years Examiner Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Last Due to (or as a consequenca of): Box 68760, Physician/Medical Due to (or as a consequence of): attending ph for use as t Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the s should be detached Division of Vital Records, P.O. 1XYas 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed cartificate has t 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No el or Attending Physician: T s aftar death. Il Director: After this carificat ed in by the funeral director, p 25. Wes case referred to medical examiner? Be 26. Placa of Deeth (Check only one) To Other: 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined To the Hospital or Atte within 24 hours after de. To the Funeral Directo completely filled in by the 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.

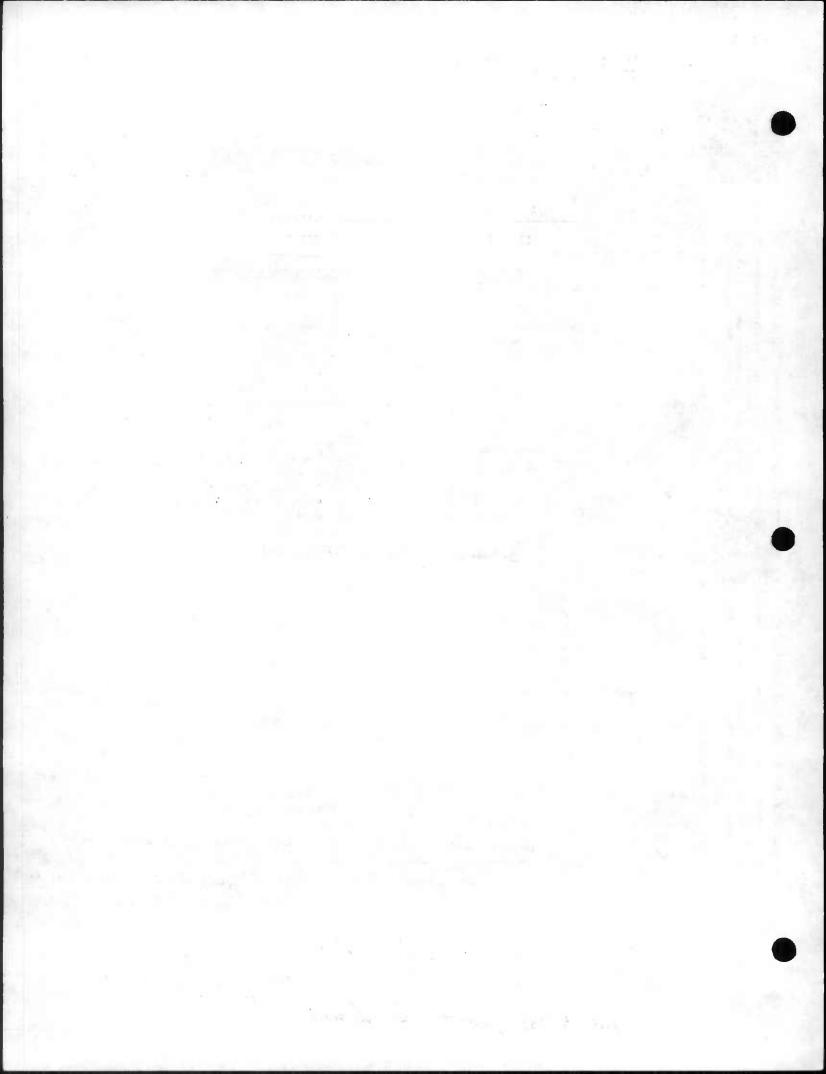
2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number death (Item 23a) (Type, Print) M. Charles St, Bultmore, mo 2/204 31. Date filed (Month, Day, Year)

DHMH 16 Rav 6/95



	RISTIN	CO)	NNOLLY Item#10b,c,f pe ITEM: #10E PER	State of Maryla r FH G771 5/6/9	nd / Dep	ertificate of	Health and Death		giene 9	14	400	
			1. Decedent's Nama (First, Middle, Last		J. HILL	-		2. Data of Dea Month	th Dev	Yaar	3. Time of Death	
	Physici /Medic		Kristin Marie (Connolly				MAY 1	, 1999	Taar	11;30AM	
N. A.	Examin		4a Facility Nema (II not institution, give 3801 PARKVIEW AV	street and number)			4b. City, Town, BALTIN	or Location of Death ORE		of Death		
	Funeral Director		5. Social Security Number 6. Se 214-92-6585 Usual Rasidence of Decedent	7. Age (In yr.	s. last birthday Yrs.	Months Days		Hrs. 8. Data of Birth (Month, Day Dec. 24	r, Year)		ce (State or Foreign y) ryland	
	death with the Maryland ms 23s or 28s-f show creat be notified at	tor	10a. Stata 10b. County Maryland Hart		City, Town or L		Baltimore			100	1. Insida City Limits 1. Yas 2 □ No	
	th with the Marylen 23e or 28e-f show	Funeral Director	10e. Street and Number 3801 PAR	KVIEW AVE.		10f. Zip Code	21207 21014		10g. Citizen of V		y? 5. A.	
020	or he	by	11. Marital Status 1 🔀 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U,S. 13.	Wes Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No		(Specify Yas or No- uerto Rican, atc.)		e - Amarica ck, Whita, et Whit	c.	
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and	2 D A	Be	17. Father's Nama (First, Middle, Last)						, Maiden Sumame)			
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200	N		19a. Informant's Name/Relationship (T)					r Rural Route Numbe		1.00	iode)	
0	The Para	-	Kathleen Marshall 20a. Mathod of Disposition		Place of Disp	osition (Name of		l Air, Ma	20c. Location -		n, Stata	
200	Pages nent of int: If Ik		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)			ematory or other pla		15///00				
	permit. Pages Department of I Important: If ite any injury or of page.		21. Signature of Funaral Service Licens			ount Crem	7	5/4/99	Baltimo	re, Ma	aryland	
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	Physician /Medical Examiner	J.C	Immediata Causa (Final disease or condition resulting in death)	GUSHOT		und De				1	Onset and Death	
1	nsit	Examiner).	,					1		
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۵	e atter	lcla	Part II. Other significant conditions cor	stributing to death but not re	sulting in the	underlying causa gi	iven in Part I.	23b. Did t	obacco use co	ntribute to 1	the cause of death?	
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5	Physician: r this certific ral director,	2	XIXI Yes 2□ No	lospital: 1 Inpatient 2	☐ ER/Outpatie	NIK JU DON		ng Homa XXRasio				
	ding P. After t	Ö	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time	Wo		28d. Describe I	ow injury occur	red	SERF.	
Vision	10 0 th	Cat	2 Accident invastigation 3 Suicide 6 Could not be	28a. Place of Injury - At			Yas 2 No	28f. Location (S				
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	M	-	30. Name and addrass of person who co	mpleted cause of death (No								
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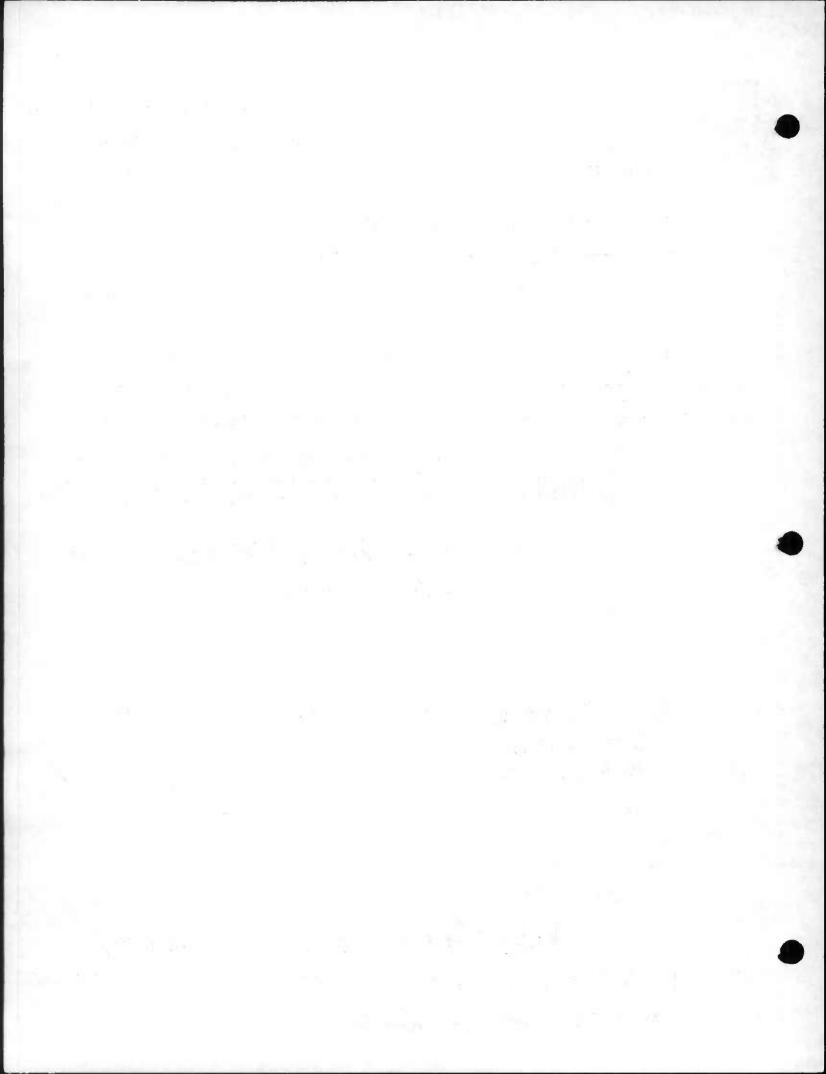
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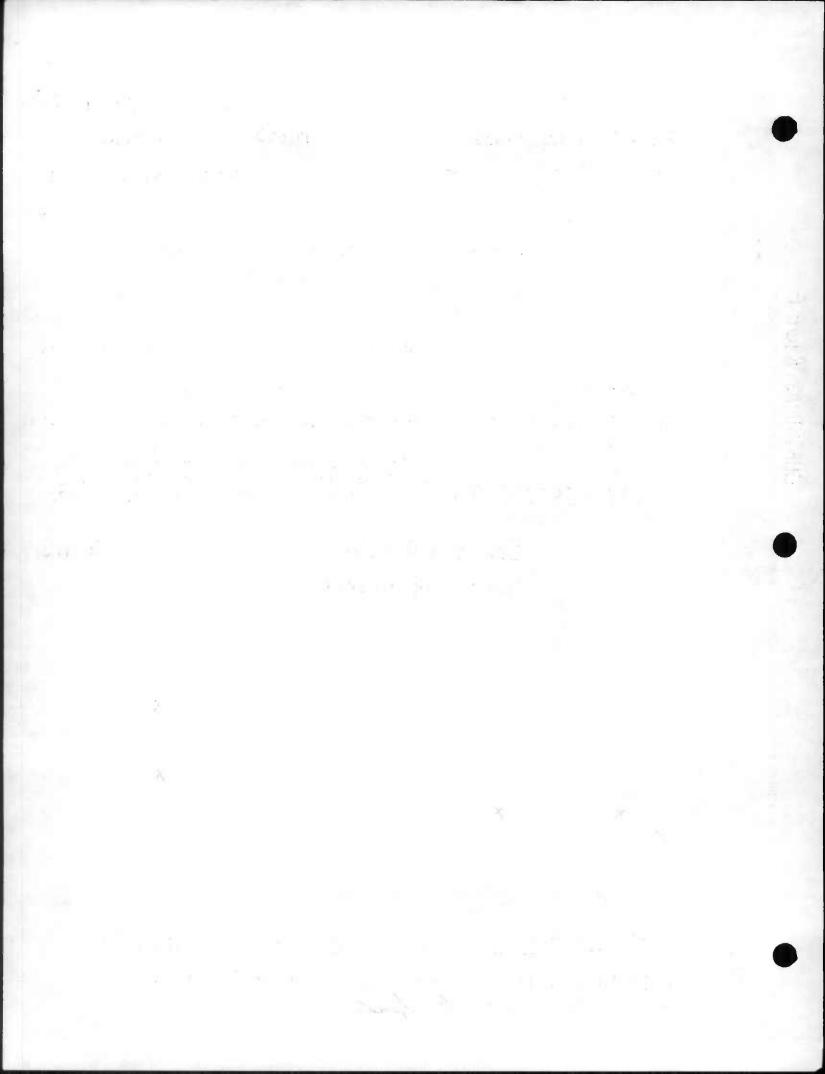


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State of Maryland / Department of Health and Mental Hygiene

			Certificate	e of Death	R	ag. No.				
	Physic		1. Decedant's Name (First, Middle, Lest) William T. Cavey		2. Data of Deet Month	h Day Y	3. Time of Death 99 12:30 pm			
	/Medi Examir		4a. Facility Neme (If not institution, give street end numbar)	4b. City, Town, or I	April Location of Death	4c. County of				
	SH'IC		621 Woodhurst Way	Catons			timore			
	Funerai Director		5. Social Security Number 6. Sax 7. Age (In yrs. lest birthdey) 1 Usual Residence of Dacadent 6. Sax 7. Age (In yrs. lest birthdey) Months	1 Year If Undar 24 Hrs. Days Hours Min.	(Month, Dev.	Year) 9 1921 M	Birthplaca (State or Foreign Country) aryland			
	the Maryland 28a-f show		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
			MD Baltimore Catonsvill	e			1 ☐ Yes 2 ☐ No			
	or 28	Dire	10e. Street end Number 10f. Zip		1	0g. Citizen of Wh	at Country?			
	ath w	rai		1228		USA				
5-0020	72 hours after death with the Maryland netural', or items 23a or 28a-f show itea Examiner must be notified at	by Funeral Director	11. Maritel Status 1 □ Naver Married 2 □ Married 3 ▼ Wildowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 ▼ Yes, Give Yaar or Dates: 13. Was Decedent Ever in U,S. Armed Forces? 1 ▼ Yes, Give Yaar or Dates:	ent of HispanIc Origin? (S ify Cuben, Mexican, Puert KN No Specify:	pecify Yas or No- p Rican, etc.)	Bleck,	American Indian, White, etc. White			
	72 hours "natural",	Completed	15. Decedent's Education 16a. Decadent's Usue (Spacify only highest grade completed) Giva kind of wor.	Occupetion	kina	16b. Kind of Busin	ness/Industry			
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/lan		To B	Harry Cavey		Cather	ine Mue	oller			
lan				(Streat and Number or Ru	rel Route Number,	City or Town, St	ete, Zip Code)			
	os 1 and of Health itam 27 other tr			hurst Way			MD 21228			
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B	permit. Depertr Importa any inji		Dawn F. McDonald 299	Address of Feeility ation Soci Frederick	Rd. Bal	ltimore	, MD 21228			
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	9		Vradeef Garg MD 716 MAIDEN 31. Date filed (Month, Day, Year) 32. Ragistrar's Signeture	CHOICE C	ANE, CA	70NSV1	(LE, My 21228			
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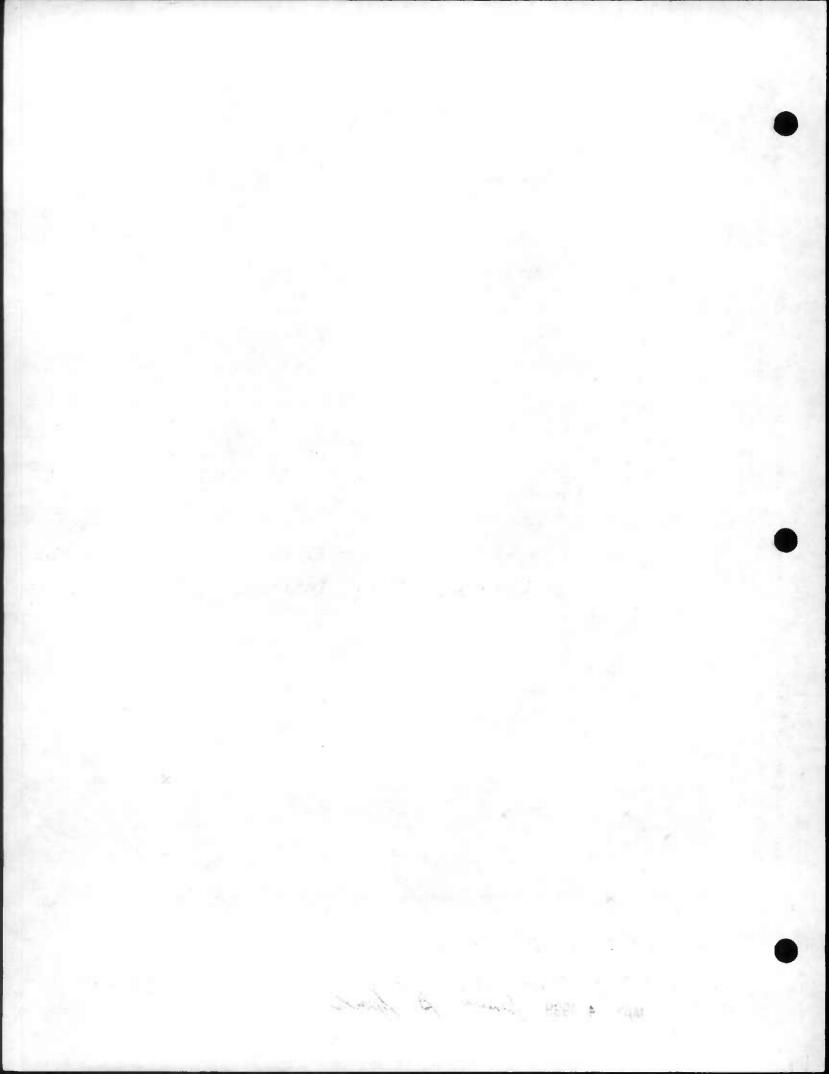




Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death MAY **Physician** CORRIS JOHN 935 PM 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY N/A5. Social Security Number If Under 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) APR 23, 19 7. Age (In yrs. last birthday) 6. Sex. 1☑•M 2□ F Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours 145-18-1648 76 Yrs. 1923 Director New Jersey Usuel Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits or 28a-f show other traumatic avent, the Medical Examiner must be notified at 1 Yas 2 No Director PA Adams Fairfield 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 14 Robin Trail "natural", or items 23a 17320 USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - Amarican Indian, Black, White, etc. permit. Peges 1 and 2 should be filad within 72 hours after to Department of Health and Mentel Hygiena. Important: if itsm 27 is marked other than "natural," or item any injury or other traumatic event, the Mentel Francis 1 ☐Xes 2 ☐ No If Yes, Giva Yaer or Dates: 1 ☐ Never Merried 2 X Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: WWII White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Relations Trans World Airlines 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Joseph W. Corris Thelma Tracy 2 19a. Informent's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Madeline M. Corris/wife 14 Robin Trail Fairfield. PA 17320 20b. Place of Disposition (Nama of cematary, cramatory or other place)
Cremation Society of PA 20a. Mathod of Disposition 20c. Location - City or Town, Stete Data 1 Burial 2 Cremation 3 Removal from Stata 5/6/99 Harrisburg, PA 4 ☐ Donation 5 ☐ Other (Specify) Cremation Society of Maryland, Inc. 21. Signature of Poperal Service Licen MyMay Dawn 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediata Causa (Final disease or condition resulting in death) DISTRESS SUNDROME /Medical RESPIRATORY Examiner Examiner 010100 attending physician and for use as the burial-transit that the death certificete be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last Division of Vitai Records, P.O. Box 68760 Physician/Medical Due to (or es a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 ☐ Unknown 1 ☐ Yee 2 ☐ No by 24b. Wara autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed peed page 2 s 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate or Attending Physician: siter death. 28. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 Yas 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Aftar 1 Natural 5 Pending invastigation sfter death. | Director: Aft 1 Tas 2 No 2 Accident 3 Suicide 6 Could not be detarmined 26f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Fune completely f (Check only one) Σ 29b. Signature and little of certifier 29c. License number 29d. Data signed (Month, Dey, Year) MD PHD. 1999 RES - 000 MAY 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) , 600 N. Wolfe St., Baltimore, MD 21281 State Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 18Am JOAN 30 LOUISE CULPEPPER 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE CITY ff Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2⊠F Months 54 230-54-1330 VIRGINIA Usuel Rasidence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XXes 2□ No MARYLAND BALTIMORE CITY 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 MONTPELIER STREET U.S.A. 21218 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: BLACK 1 Yes 2000 Spacify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12th grade 2 yrs FIELD ADMINISTRATOR BGE 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) JAMES BROWN BERNICE ELDRIDGE 19a. Informent's Name/Reletionship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eddie Culpepper/Husband 830 Montpelier St., Baltimore, Maryland 21218 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Stata Date 1 Burial 2 Cremetion 3 Removel from Stete ARBUTUS MEMORIAL 5-6-99 BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Neme and Address of Fecility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in daath) Sequentially list conditions, if any, leeding to immediate cause. Entar Undarlying Ceusa (Disaasa or injury that initieted events resulting in death) Lest Due to (or es e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospitel: Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding invastigation Neturel 2 Accident

pue o the signed by this Division

or Attending n 24 hours after death.

The Funeral Director: After the further t vithin 24 hour To the Fune completely fi

Physician

/Medical

Examiner

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Funeral

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Completed

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Certification:

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Baltimore, Maryland 21215-0020

State Registrar

31. Dete filed (Month, Dey, Year)

3 Suicide

29a. Certifia

4 ☐ Homicide

(Check only one)

29b. Signeture end title of continue

30. Neme end address of person who completed cia

1999

6 Could not be datamined

28e. Plece of Injury - At home, larm, street, factory, office building, atc. (Specify)

cause of deeth (Item 23a) (Type, Print) Memoria 32. Registrer's Signeture

29d. Date signed (Month, Day, Year)

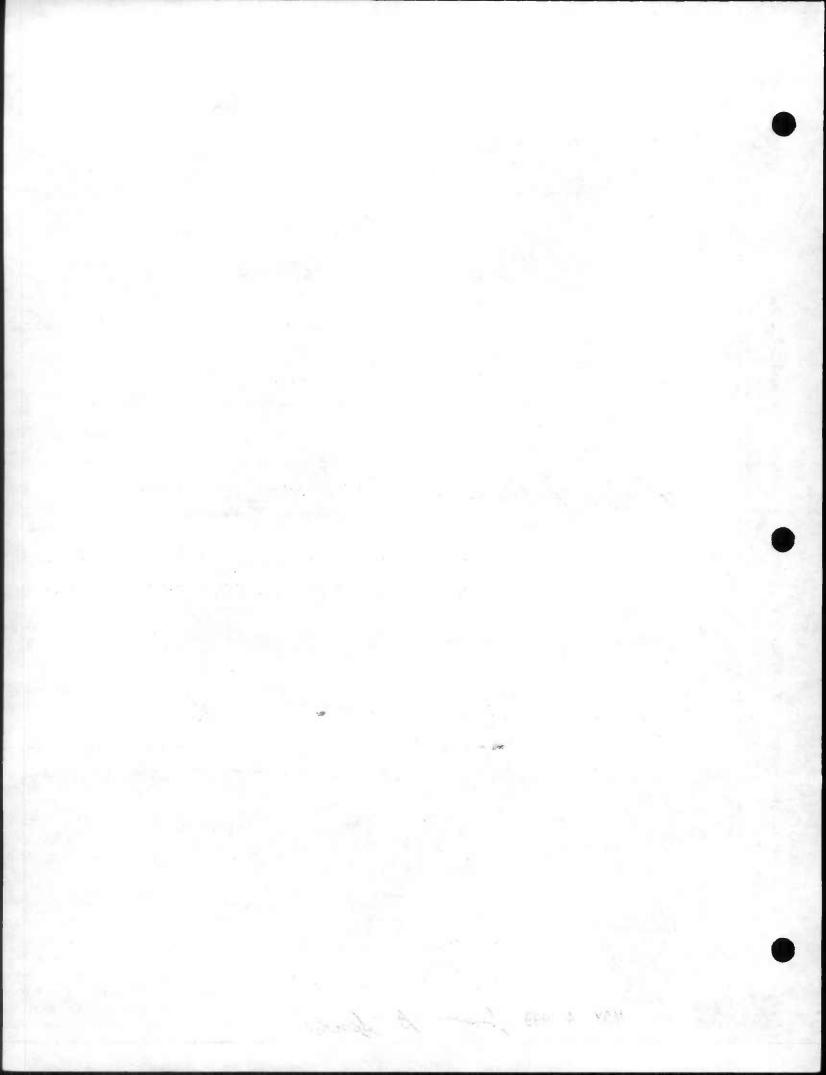
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

1 Yes 2 No

Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner steted.

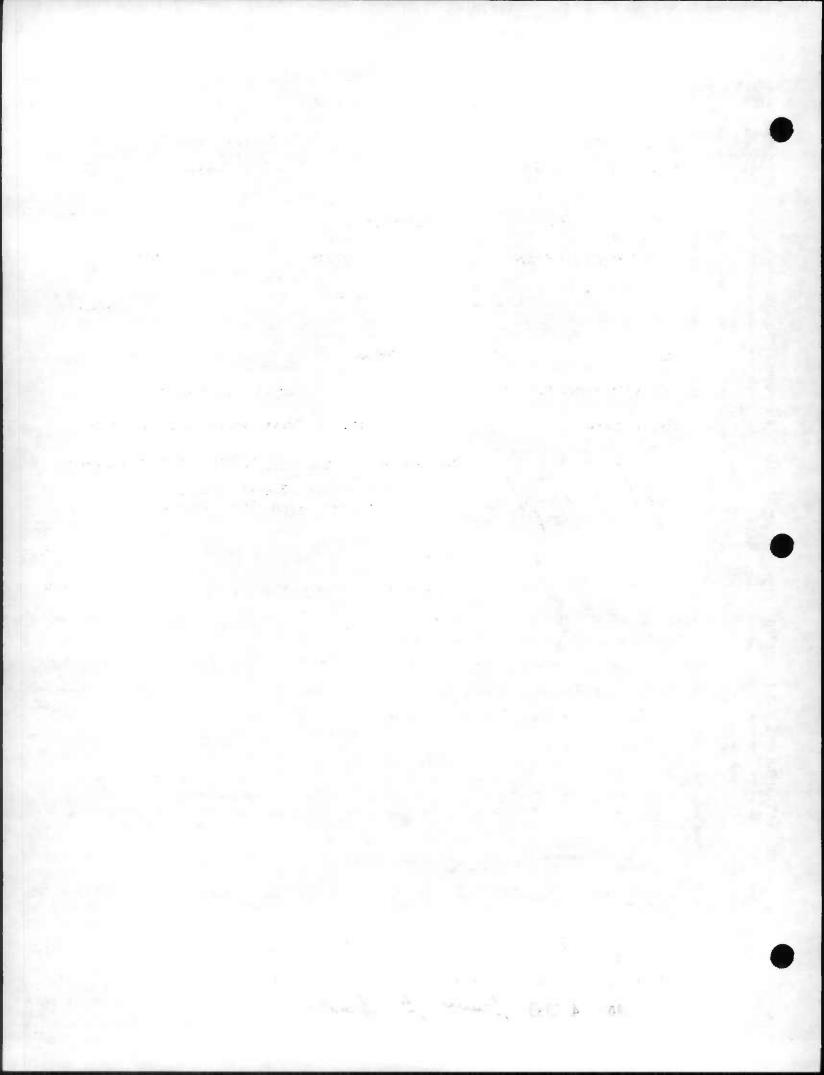
29c. License number



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			Certificate of	Death	Re	eg. No.	14400	
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Physician /Medical	CHARLES ERNEST		Coope		MAY		999 6: 22 PA	
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	GOOD JAMORITAN MOJE	TOL		BATTIN		MD	21238	
uneral rector	5. Social Security Number 6. Sex 7. Age 1 M 2 □ F 7. Age	72 Y	dey) If Under 1 Year Months Deys		8. Date of Birth (Month, Dey, 4/7/27		B. Birthplece (Stete or Foreign Country) Liberia	
>	Usuel Residence of Decedent 10a. Stete 10b. County	10c. City, Town	os I postigo				10d Inside City Limite	
be notified at Director							10d. Inside City Limits 1 ☑ Yes 2 □ No	
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or 28s-f.s. be noutled Director	10e. Street end Number		10f. Zip Code		10	0g. Citizen of Wh	et Country?	
s 23a Numb	2303 Pentland Drive		2123		7 11	USA	A	
r itams 23d ciner must Funeral	11. Marital Status 12. Was Decedent E Armed Forces?		 Was Decedent of If Yes, specify Cut 	pen, Mexican, Puerto	Rican, etc.)		American Indien, White, etc.	
0 =	1 Never Married 2√2 Married 1 Yes 2 2 N 1 Yes, Give Yeer or Detes:	10	1 ☐ Yes 2 🖺 No	Specify:		Specify:	DI A CIV	
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	(Specify only highest grade completed)	100. [Decedent's Usual Occu Give kind of work done life. DO NOT use retire	during most of work	ing	TOD. TUING OF DUST	nosa modelly	
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marked other imatic event, I To Be Co	17. Fether's Neme (First, Middle, Last)		Dailice	18. Mother's Name	e (First, Middle, N			
ic ever	Charles Henry Cooper			Marana	D. Tala			
T T	19a. Informent's Name/Reletionship (Type, Print)	196.	Melling Address (Stree		D. John		tete. Zip Code)	
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other	Albert Cooper Son 20a. Method of Disposition	20b. Plece of I	Disposition (Neme of				21234 Ity or Town, Stete	
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jury	4 □ Donetion 5 □ Other (Specify)	Dulaney	Valley Me		/7/99	Cockeys	ville, MD	
Important: any injury once.	21. Signature of Funeral Service Licensee		The Johns	on Funore	1 Home.	Dλ		
_ 40	I fathe 1 teups		8521 Loch	Raven Bl	vd. Tow	son. MD	21286	
	23a. Hart / Enter the disease, or complications that caused shock, or heart feilure. List only one cause on eech lin	the death. Do no	ot enter the mode of dy	ing, such es cardiac	or respiretory erre	est,	Approximete Intervel Between	
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the burial-transit dical Examir	Sequentially list conditions,	A = :	,		Fe 200006			
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etached for use e	Pert II. Other significant conditions contributing to death bu	it not resulting in	the underlying cause g	iven in Pert I.	23b. Dfd to		ribute to the cause of death	
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D 0	27. Manner of Deeth 28a. Date of Injun	y Yeer) 28b. Ti	me of 28c. Injury	ork?	28d. Describe ho	w injury occurred	d	
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or: After this one funeral direction: To	2 Accident investigation	4.1	m, street, fectory, office	•	28f. Location (St City or Town	reet end Number n, State)	or Rural Route Number,	
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ni ofrector: After this of the by the funeral direction of the control of the con	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Inju	ry - At home, ten . (Specify)						
Funeral Director: After this of stay filled in by the funeral director director: Todical Certification: To	2 Accident 3 Suicide 4 Homicide 28e. Placa of Injubilding, etc 29a. Certifier (Check only) Medical Examiner: On the basis of	(Specify) f my knowledge, examination and						
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Registrar



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State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Dete of Deeth Month 1. Decedant's Neme (First, Middle, Last) 3. Time of Death Yeer 6:45 AM **Physician** COOPER 30 1999 MARY APR /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth University of Maryland Medical Center Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 12/25/1924 If Linder 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months 10 M 20 F 74 217-20-8140 Director Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in a Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 No Director Maryland Baltimore 10f. Zip Code 10a. Citizen of Whet Country? 10e Street and Number 805 N. Monroe Street U.S.A. 21217 Funeral 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? I ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black à 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedant's Education (Specify only highest grade completed) 16e. Decedant's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) 10 Domestic Housekeeping 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Be Guy Watson Louise Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat end Number or Rurel Route Number, City or Town, Stete, Zip Code) Rosie Pitts / Sister 46 S. Catherine St., Baltimore, Maryland 21223

20b. Plece of Disposition (Neme of cemetery, cramatory or other plece)

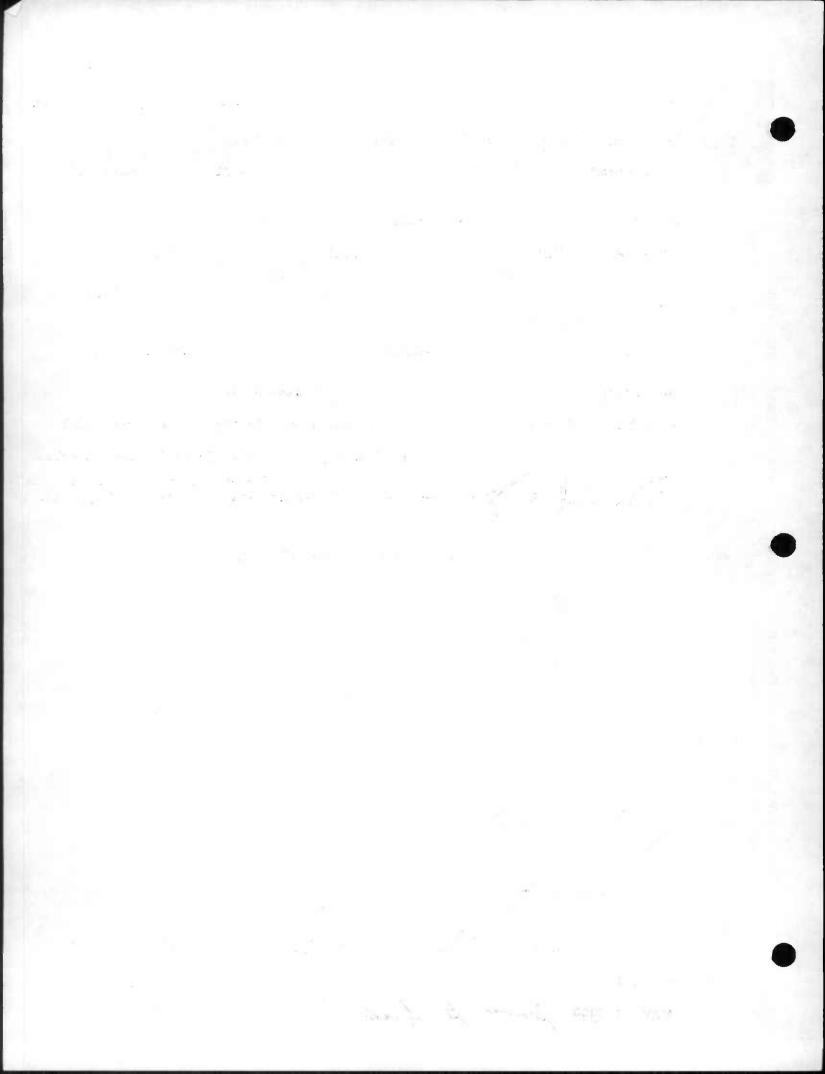
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20c. Location - City or Town, State 20e. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removel from Stete Mt. Zion Cemetery 05/06/99Landsdowne, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility The Derrick C. Jones Funeral Hm. 21. Signeture of Funeral Service Licensee 4611 Park Heights Ave., Baltimore, Maryland21215 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on the line. Approximate Interval Between Onset and Death **Physician** hemorrhage /Medical Immedieta Causa (Final disease or condition resulting in daeth) Examiner Examiner The law requires that the death certificate be executed physician end the buriel-transit Saquentially list conditions, if eny, laading to immediata causa. Enter Underlying Cause (Disaasa or Injury thet initiated evants resulting in death) Lest Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of) signed by the e Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 No þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed s certificete hes b director, pege 2 s 1 ☐ Yes 2/ No 1 ☐ Yas 2 ☐ No or Attending Physician: director, Be 25. Was casa rafarred to medical examiner? 26. Placa of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1) Inpatient 3 DOA 2 ☐ ER/Outpetient this funeral 28e. Dete of Injury (Month, Dey Year) 27. Mannar of Death 28b. Time of 28d. Dascribe how injury occurred 28c. Injury et Work? 5 Pending Invastigation 1) Naturel 2 Accident 1 Yes 2 No death. within 24 hours after death To the Funeral Director: A completely filled in by the f 6 Could not be detarmined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28a. Place of Injury - At home, farm, streat, fectory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physicien: To the bast of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) end menner stated. edicai 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Latura RESIDENT 30. Nema and address of person who completed causa of deeth (Itam 23a) (Type, Print) Ste 125D Baltimore, MD 21201 5 Greene 8t. KATRINA MURPHY 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State

Registrar

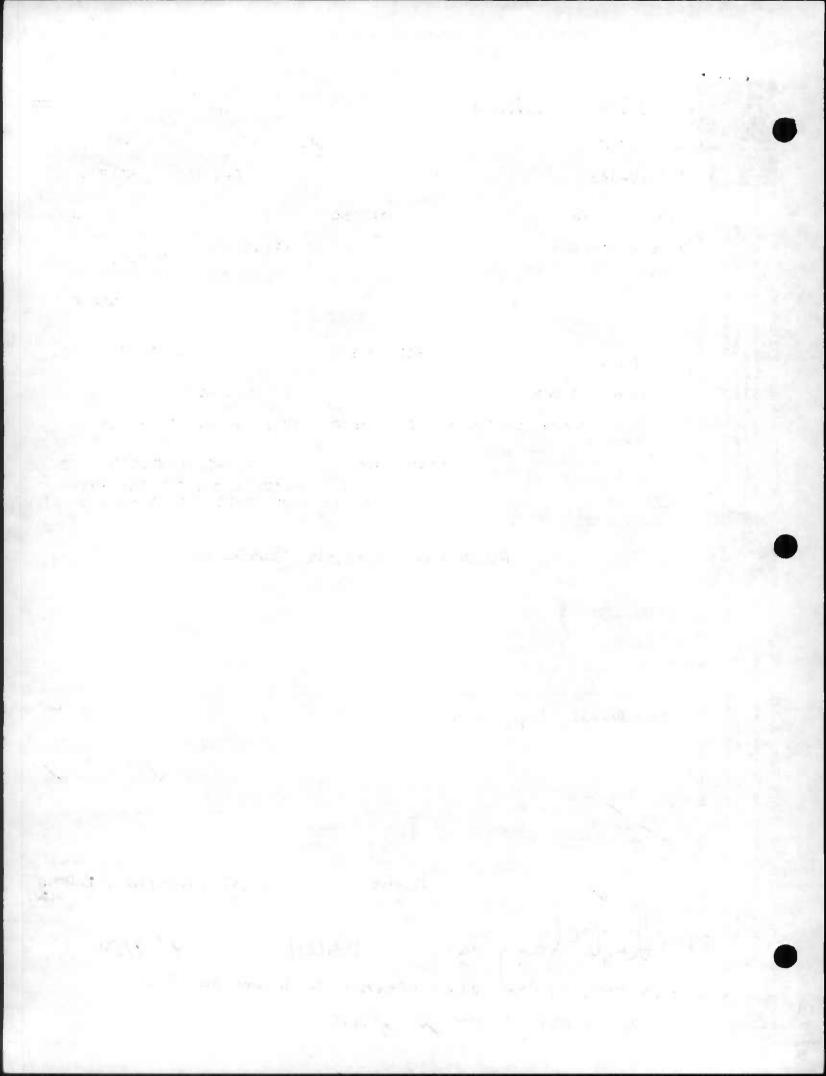
1999 MAY



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Year **Physician** 4:45pm AMES DIXON 25, 1999 4c. County of Death APR /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) Examiner BALTO, 2319 KOKO LANE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1 M 2□F Months Deys Hours Min Yrs BALTO. **Director** 87 215-10-6427 Usual Residence of Deceden with the Meryland r 28a-f show 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A BALTIMORE 1 XYes 2 □ No Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zlp Code "natural", or items 23a or 21216 2319 KOKO LANE U.S.A. death v Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status d be filed within 72 hours efter de antal Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Detes: 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ BLACK 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) Elamantary/Secondery (0-12) College (1-4or 5+) CITY OF BALTO. SUPERVISOR 17. Father's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event, bace. 18. Mother's Neme (First, Middle, Maiden Sumame) P EFFIE DIXON WILLIAM DIXON 19a, Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) ANTHONY DIXON (GRANDSON) 3531 ELMORA AVE, BALTO. MD 21213 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Purial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) MOUNT 4-29-99 LANDSDOWN, MD ZION 22. Name end Address of Fecility
I,EROY O DYETTE & SON FUNERAL HOME 21. Signature of Funerel Service Licens 21207 4600 LIBERTY HGHTS AVE, BALTO. MD 23 Part. Enter the dispart, or complications that caused the deeth. Do not enter the mode of dying, such as cardlac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Prostate Carcinoma 34-5 Metastatic **Examiner** Dua to (or as e consequence of) Physician/Medical Examiner physician end s the buriel-transit certificate be executed Sequentially list conditions, if eny, leeding to immediate ceusa. Enter Underlying Cause (Disaasa or Injury that initiated evants resulting in death) Last Due to (or es e consequence of): Box 68760. Due to (or as e consequence of) 80 for use es The lew requires that the deeth by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 2 Subdenal lygroma Records, by 24b. Wara autopsy findings eveilable prior to completion of cause of deeth? should I 24a. Wes en eutopsy performed? Completed 32 certificete he 1 Yes 2 N No 1 Yes Division of Vital Hospital or Attending Physician: Be 25. Wes cese referred to medical 26. Pleca of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No To this 27. Menner of Deeth 28c. Injury et Work? 28e. Dete of Injury (Month, Day Year) 28d. Dascribe how Injury occurred Certification: After 5 Pending Investigation 1 Naturel 1 Yes 2 No death. 2 Accident Director: / 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, straat, factory, office building, etc. (Specify) efter 4 \(\text{Homicide} \) 2319 Koko have Baltho To the Hospital within 24 hours of To the Funeral Completely filled name 10 Certifying Physician: To the best of my knowledga, death occurred et the time, deta end plece, end due to the ceuse(s) end mennar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and placa, and dua to the causa(s) and mannar stated. 29a. Certifier edical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31884 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Lindentur Baltimere MD 2/201 Hugh Gregory
31. Dete filed (Month, Day, Year) 827 32. Registrer's Signeture State Sporks

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 44 14 11 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1999 4:30am MAY COWAN DOWNS /Medical 4b. City. Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner BAI,TO.
If Under 24 Hrs. B. LORIAN NURSING HOME If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F -62 47 Yes Director BALTIMORE 8-27-51 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE Yes 2 No MD Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21205 904 N. BROADWAY U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Merried 2 Merried 1□ Yes 2□ No Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If itam 27 is marked other th any injury or other traumatic svant, the 9 SELF EMPLOYED MAINTENANCE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) å SAMUAL DOWNS MARY CLAGGETT 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 N. BROADWAY ST, BALTO. MD MARY CLAGGETT (MOTHER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) MT. ZION 5-8-99 LANDSDOWN, MD 21 Signature of Funeral Service Line 22 Name and Address of Facility LEROY O DYETT & SON FUNERAL HOME 200 4600 I.IBERTY HGHTS AVE, BAI.TO. MD 21207 at enter the mode of dying, such as cardiac or respiratory errest, Approximate 23a. Part1. Enler the dis-shock, or heart failum Approximate Interval Between Onset and Daath Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Examiner DEHYDRATION Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown by 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 21 No 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Neturel 5 Pending 1 TYes 2 No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 - Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

State Registrar

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P.O. Box 68760,

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Division of Vitai

Baitimore, Maryland 21215-0020

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

1999 **DHMH 16 Rev 6/95**

31. Date tiled (Month, Day, Year)

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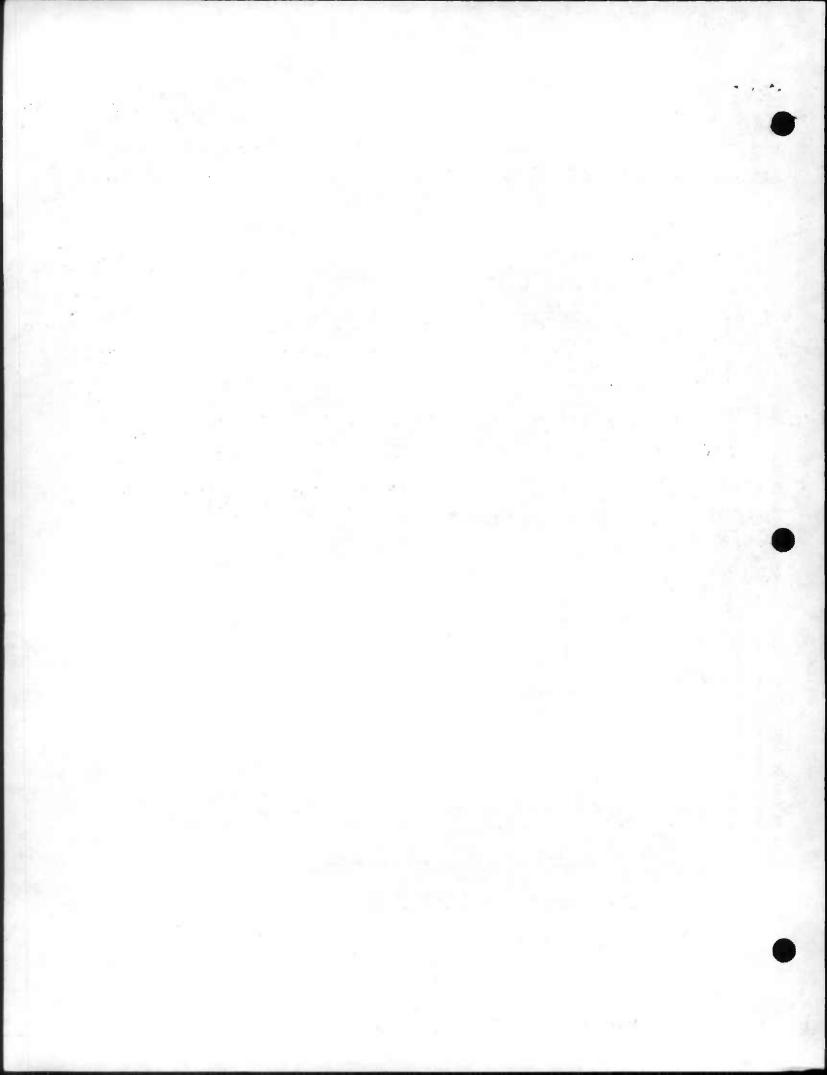
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MORTHERM

32. Registrar's Signature

ORIGINAL

SALTIMORE



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** 10:45 PM 1999 April 30, THOMAS DIETZ , SR. /Medical 4e Fecility Neme (If not institution, give street end number, 4b. City. Town, or Location of Deeth 4c. County of Death Examiner BALTIMO RE
If Under 24 Hrs. 8. Date
Hours Min. (Mo. MEMORIAL HOSPITAL MOIMU If Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Deys Months 10M 20F Yrs 80 Director AUG. 18,1918 213-01-011 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examinar must be notified at 1PYes 2 No Directo MD BALTIMORE the 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) # TIW U.S.A. 14. Race - American Indien SI. 1013 4100 N. CHARLES Funeral 12. Wes Decedenf Ever in U,S. Armed Forces? 11. Meritel Status Bleck, White, etc. 1 Never Merried 2 Married 1 ☑Yes 2 ☐ No WWII. If Yes, Give Year or Detes: ADMV Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced ARMY WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "I any Injury or other traumatic event, the Max MACHINERY Elementary/Secondery (0-12) Collega (1-4or 5+) 12 V.P. SALES MANUFACTURING 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maiden Sumame) Be ARTHUR LEROY DIETZ EVA EDNA NASH 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 4100 N. CHARLES ST. #1013 BATIMORE, MD. 21218
ca of Disposition (Name of Date 20c. Location - City or Town, State ESTHER C. DIETZ SPOUSE Date MAY 4. 20e. Mathod of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetery or other plece) 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Ramovel from Stete 4 ☐ Donation 5 ☐ Other (Specify) DULANEY VALLEY MEM. GONS. 1999 THONIUM, MD. 22. Name and Address of Facility EVANS CHAPEL OF CHIMES 21. Signature of Funeral Service Licensee 23a. Fert f. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. TIMONIUM , MD. Approximete Intervel Between Onsef end Death **Physician** immediate Ceuse (Finel diseesa or condition resulting in deeth) /Medical 8 days Rilmonary edema Examiner Due to (or as a consequence of): 8 days Instable Angina Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Disaasa or Injury that initioted events resulting in death) Lasf Due to (or es e consequança of): neart disease 9 years Chronic ischemic Physician/Medical Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 Ø Unknown cerebro vascular accident, by 24b. Were eutopsy findings eveilable prior to 24e. Wes en autopsy performed? Hypertension completion of cause of death? 1 Yes 2 No 1 Yas 2 No 25. Wes cese referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 27. Menner of Death 28e. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. fnjury et Work? After Division 1. Natural 5 Pending or Attending after death. 1 Yas 2 No Invastigation 2 Accident 6 Could not be datermined 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida Hospital
 24 hours a
 Funeral D 29e. Certifier (Check only one) 12 Certifying Phyelcian: To tha best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated. To the Hosp within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Dafe signed (Month, Dey, Year) Jana Onudie. MO 2438946 April 30, 1999 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) University Pkway Baltimore, MO21218 Maria Helena F. Onuchic 201 E.

DHMH 16 Rev 6/95

Registrar

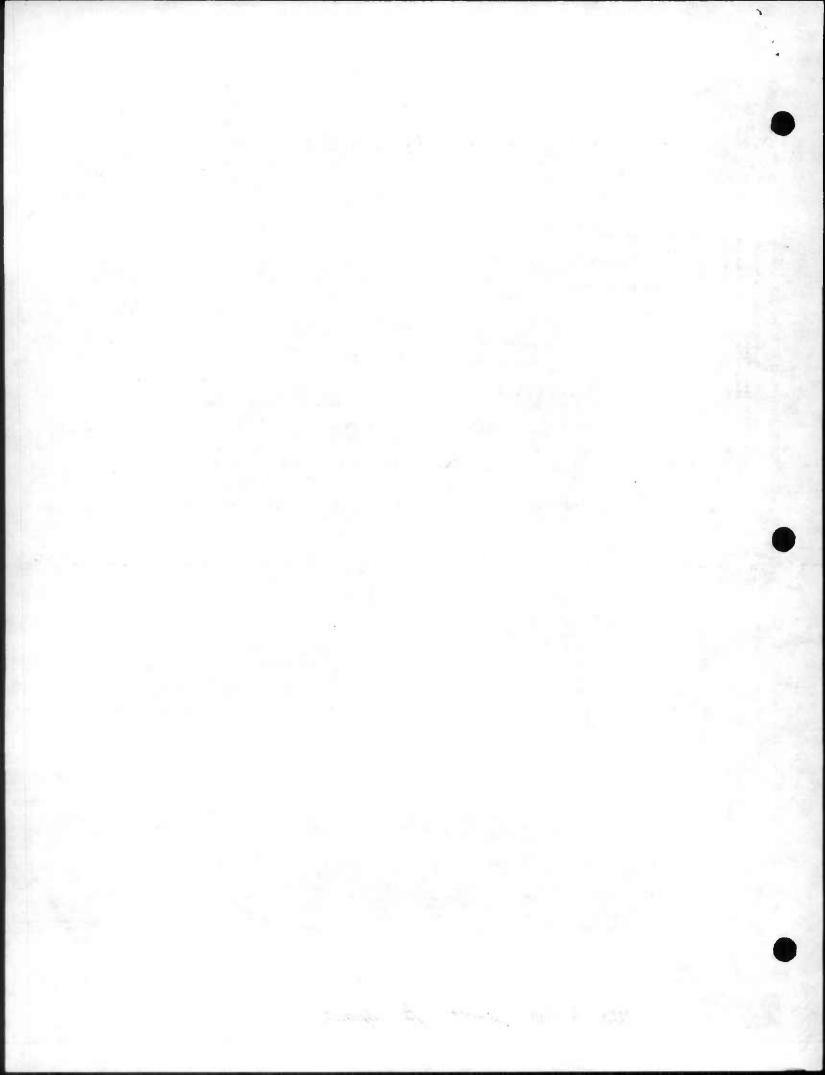
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32. Registrer's Signeture

1999



Box 68760. P.O. ARTHUR DOWELL. Records, of Vital Division

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30. Name end eddress of

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arean who completed/cause of deeth (Item 23e) (Type, Print)

V. Dixon King, Jr. St Agnes HealthCare 900 Caton Avenue Baltimore, MD 21229 souks

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) inpd manner stated.

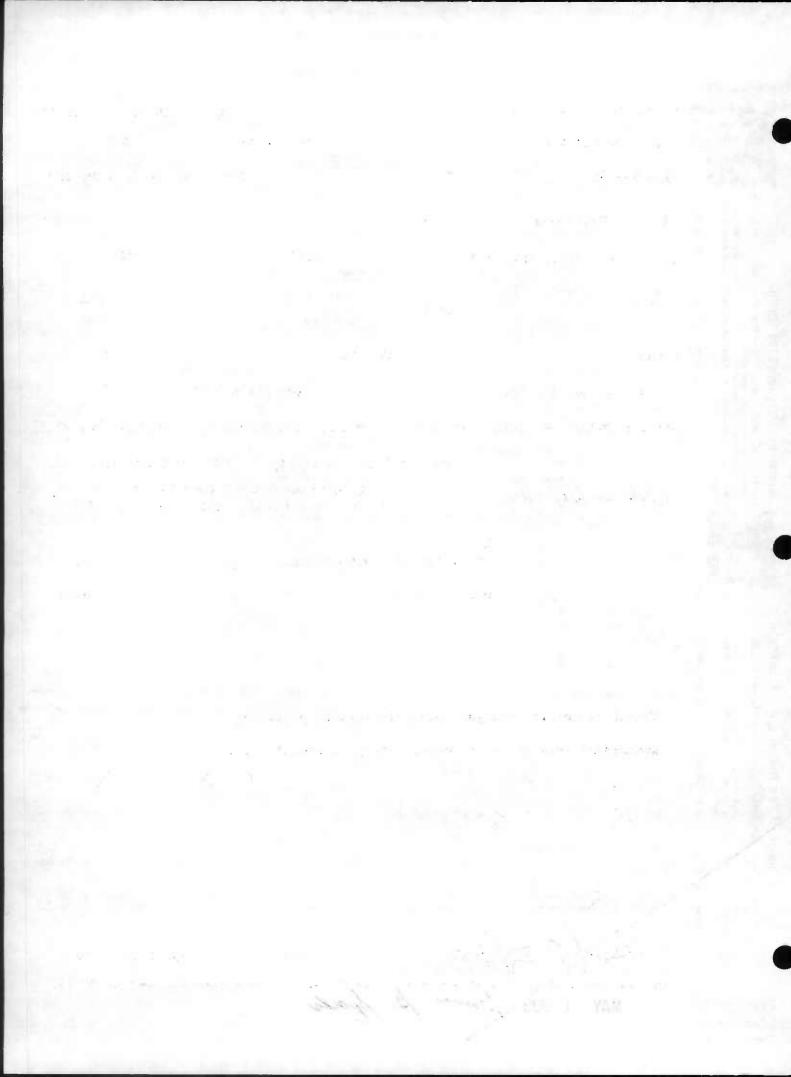
29c. License number

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29d. Date signed (Month, Day, Year)

April 29, 1999

DHMH 16 Ray 6/95

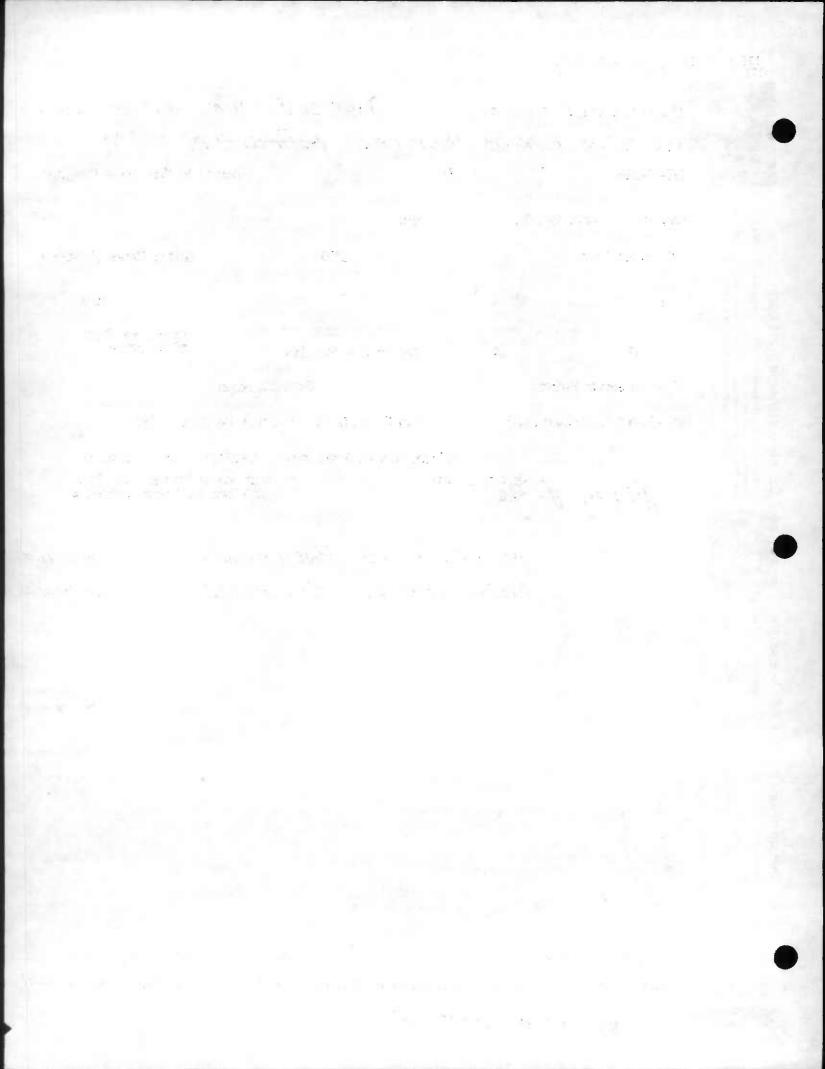


Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM: #1 PER MD G771 5-12-99 WR. ITEM: #4A PER MD G771 5-4-99 WR. Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Deeth Da Vear Month **Physician** 2 DICK SON 1999 MAY LARENCE FARNSWORTH /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, giva straat and number) 4c. County of Death Examiner MD2 BALTIMORE If Under 24 Hrs. N/A HOSPITAL JOHNS TOPKIN If Undar 1 Year 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1⊠M 2□ F Months Days Hours Min. 236-40-3936 72 January 10, 1927 Organ Cave, W. Va. **Director** Usual Residenca of Decedent the Marylend 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 No Maryland Baltimore Co. Timonium Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Hygiene. other than "natural", or items 23a or " rent, the Medical Examiner must be ! with 1904 Forest Court 21093 United States of America death Funerai 14. Race - Americen Indian, Bleck, White, etc. 12. Was Dacedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Giva Yaer or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 11. Marital Status filed within 72 hours efter 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3 X Widowad 4 Divorced Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Farm Credit Banks of Baltimore College (1-4or 5+) Elementary/Secondery (0-12) Senior Vice President other 7 Is markad other traumatic event, 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middla, Last) permit. Pages 1 and 2 should be f Department of Heelth and Mental I Important: If Item 27 Is marked of any Injury or other traumatic eve Charlotte Mason Edgar Farnsworth Dickson 2 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Mr. Richard R. Dickson (Son) 1904 Forest Court Timonium, Maryland 21093 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Ramoval from State Hilltop Service Corporation 5/03/1999 Towson, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. 21. Signature of Funerel Servica Licensea Jeffrey L. Gair 1050 York Rd. Towson, Md. 21204 air 0 23a. Part Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical a. ASPERGILLUS

Due to (or es a consequence of): THERE WEEKS Examiner MYELODYSPLASTIC SYNDROME Examiner physician end s the buriel-transit Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, death certificate be Physician/Medicai Dua to (or as a consequence of): Ses 950 Po signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 MUnknown þ 24b. Were eutopsy findings eveilable prior to 24a. Was en eutopsy performed? Completed completion of causa of death? certificate has b 1 ¥ Yes 2 □ No 1 Tyes 2 No Attanding Physicien: 25. Was case referred to medicel examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☑ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 DNatural 5 Pending Investigation or Attanding after death. Director: Aft d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 24 hours after Funeral Directletely filled in b 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) and manner steted. 29a. Certifier edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. Licansa number 29d. Data signed (Month, Dey, Year) 29b. Signeture and title of certifian RE5-000 MAY2,1999 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Subramanyan, Johns Hopkins Hospital, 600 N. Wolfest, Baltimore, MD 21287 Smitha 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State Registrar DHMH 16 Rev 6/95

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Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 10:40pm Dietnew Vernon May 1999 /Medical 4b. City, Town, or Location of peath 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hopkins Bayview Medical Center Baltimore Johns If Under 24 Hrs. Birthplace (State or Foreign Country)
 . 7. Age (In yrs. last birthday) If Under 1 Year 5. Sociel Security Number **Funeral** 1 M 2 F Months Deys Hours 73 214-20-2046 NOV. 14, Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan near of Health and Mental Hygiena.

Int. If them 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic svent, the Modical Examination must be not the second. DUNDALK 1 Yes 2 No BALTIMORE Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number DRIVE S. A. 3515 21222 OGANVIEW Funeral 12. Wes Decedent Ever In U,S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 Never Married 2 Married 1 Yes 2 No Specify: altimore, Maryland 21215-0020 Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1944-46 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) DESIGN | 17 (17) | 18. Mother's Neme (First, Middle, Melden Surname) 17. Fether's Name (First, Middle, Last) Be DIETRICH KRAMER MARTIN ELIZABETH 19a. Informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DRIVE, Dundalk, MD 21222 3515 ANNA MAXINE DIETTICH LOGANVIEW WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Dete 20a. Method of Disposition CATOnsville 1 ☐ Buriel 2 Cremation 3 ☐ Removal from State Department of Important: If METRO 4 ☐ Donetion 5 ☐ Other (Specify) CremATORY 22. Nome and Address of Facility
CONNELLY FUNERAL HOME
7/10 Solles Point RD. 21. Signature of Funeral Service Licens of bundalk MD 2122 7/10 23a. Perf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feiture. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** · Large Right intracranial bleed with herniation /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner hysician and the buriel-transit requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in death) Last Due to (or es e consequenca of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of) ettanding pl ed by the e Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of deeth? 1 Yes 2 No 3 Probably dunknown rostate cancer signed b Division of Vital Records. þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes an autopsy Completed performed' page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funarai 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After 5 Pending investigation 1 Naturel after death. 1 ☐ Yes 2 ☐ No Accident
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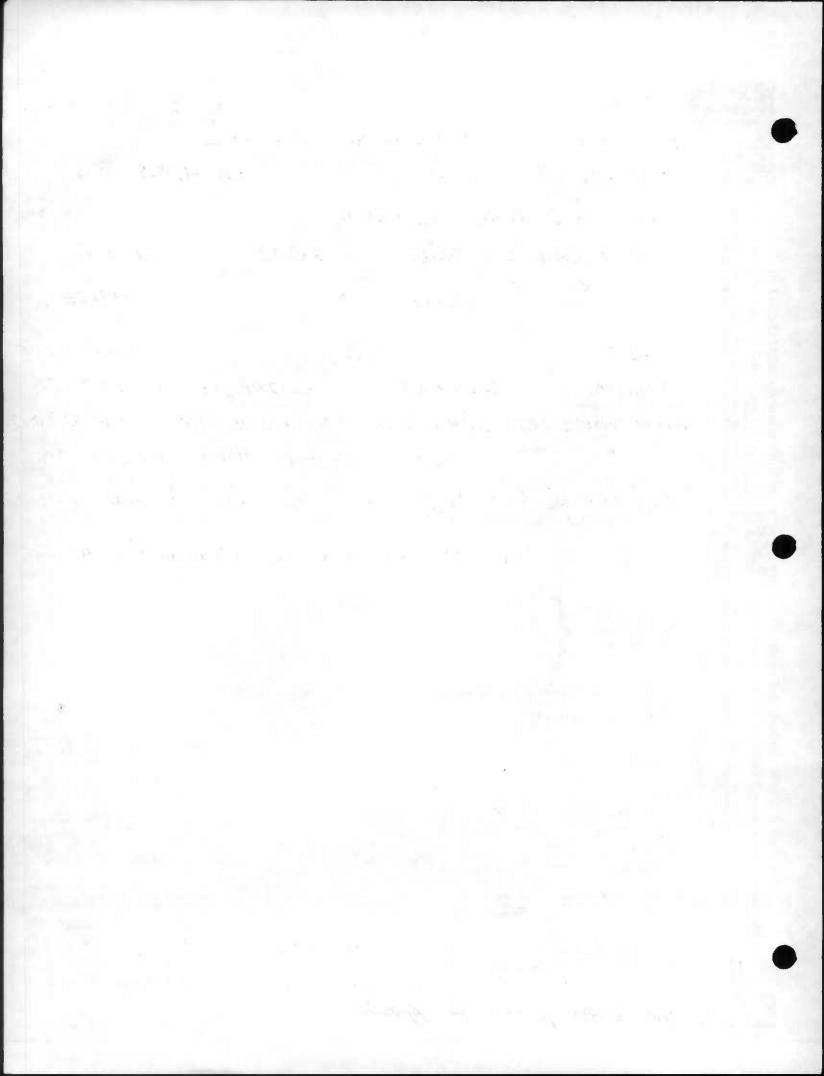
2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) and menner steled. edical 29a. Certifier To the Hosp within 24 hou To the Funer completely fil 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of partifier 29c. License number Vanker MD THIS 97012 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) Bayview Medical Center, Baltimore Maryland Johns Hopkins Dankwa 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

4 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death A Pril **Physician** Ferguson 12:15 Am Frank 1999 29 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, giva streat and number) Examiner Baltimore Bayview Medical Center If Under 1 Yaar | If Undar 24 Hrs. Birthplace (State or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 15KM 2□ F Yrs. Director Usual Residence of Decedent with the Marylend 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-1 show Harford Edgewood 1 ☐ Yes 2 K No Directo Md 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 2208 21040 Moughby Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 Dives 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Bleck, White, etc. 11. Mental Status permit. Peges 1 end 2 should be filed within 72 hours effer. Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examine 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1□ Yes 20 No Specity: White Spacify: þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) andscaping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middla, Last) Be terguson 10 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type Print) Date 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses vans 23a. Fart1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line. Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in deeth) /Medical from 00/00 Metastatic disease heunth Examiner Due to (or es a consequence of): Examiner One YeAR Colon Concer requires that the death certificate be executed ettending physician end for use es the bunal-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): rasulting in death) Last Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed page 2 hes 200 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 After this 28e. Date of Injury (Month, Dey Year) funeral 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred or Attending 1 Netural 5 Pending Investigation efter death. 1 TYes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital o within 24 hours of To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. Licensa number on (PAS) to pril 29 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Boyciew medical center 4940 Eastern Ave Bultimore mo SCOTT ZAFT 31. Date filed (Month, Day, Tear) 32. Ragistrar's Signeture State MAY Registrar

MAY 4 1989 See- 1 June 1

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month eed **Physician** Erome Apri 1999 10:50 AM /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 9508 WHITE SPRING WAY COLUMBIA HOWARD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
JUNE 2,1937 7. Age (In yrs. lest birthday) 6. Sex 1 SM 2□ F Birthplece (State or Foreign Country) **Funeral** Months Deys Hours Min 058-30-0280 Yrs. 61 NY Director Usuel Residence of Decedent the Meryland 10a State 10b. County 10c. City. Town or Location 10d. inside City Limits 2 should be filed within 72 hours efter death with the Marylen end Mentel Hygiene. Is marked other than "naturel", or frems 23s or 28s-f show summatic event, the Madical Examinat must be notified. 1 ☐ Yes 2 No COLUMBIA Director HOWARD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9508 WHITE SPRING WAY 21046 U.S.A. Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11, Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) CORPORATE FINANCIAL OFFICER FREED & ASSOCIATES 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) 2 (UNKNOWN) SAMUEL MOLLY 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Peges 1 end 2 st Department of Health end Important: If Item 27 is n any injury or other traun 9508 WHITE SPRING WAY - COLUMBIA, MD 21046 GLORIA FREED / WIFE Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Surial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/2/99 COLUMBIA MEMORIAL PARK COLUMBIA, MD 21. Signeture of Funeral Service Liganse 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Onset and Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) (ardiac Examiner ardovascolar Examiner nosclentsc physicien end s the buriel-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): O. Box 68760 90 Physician/Medical Due to (or as e consequence of): law requires that the death certificete 80 ettending p Se by the e Pert II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the cause of death? \$⊟ Probably 4 Unknown 1 ☐ Yes 2 ☐ No ty perlipidema þ Division of Vital Records, 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? rabeter mellits 24e. Was en eutopsy performed? Completed hes **e**0ed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only Hospitel Other: 4 Nursing Home 1 ☐ Yes 2 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Mesidence 6 □Other (Specify) this funeral 27. Menne of Deeth 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28h Time of 28c. Injury et Work? Certification: After 1 Naturel 2 Accident 5 Pending investigation n 24 hours efter death.

Ne Funerel Director: Al 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. edical 2 Madical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and menner stated. (Check only one) within 2 29b. Signature and title of page 29c. License number 29d. Dete signed (Month, Dev. Year) To 199 30 Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) acrol Park 14201 miD

ause

31. Dete filed (Month, Day, Year)

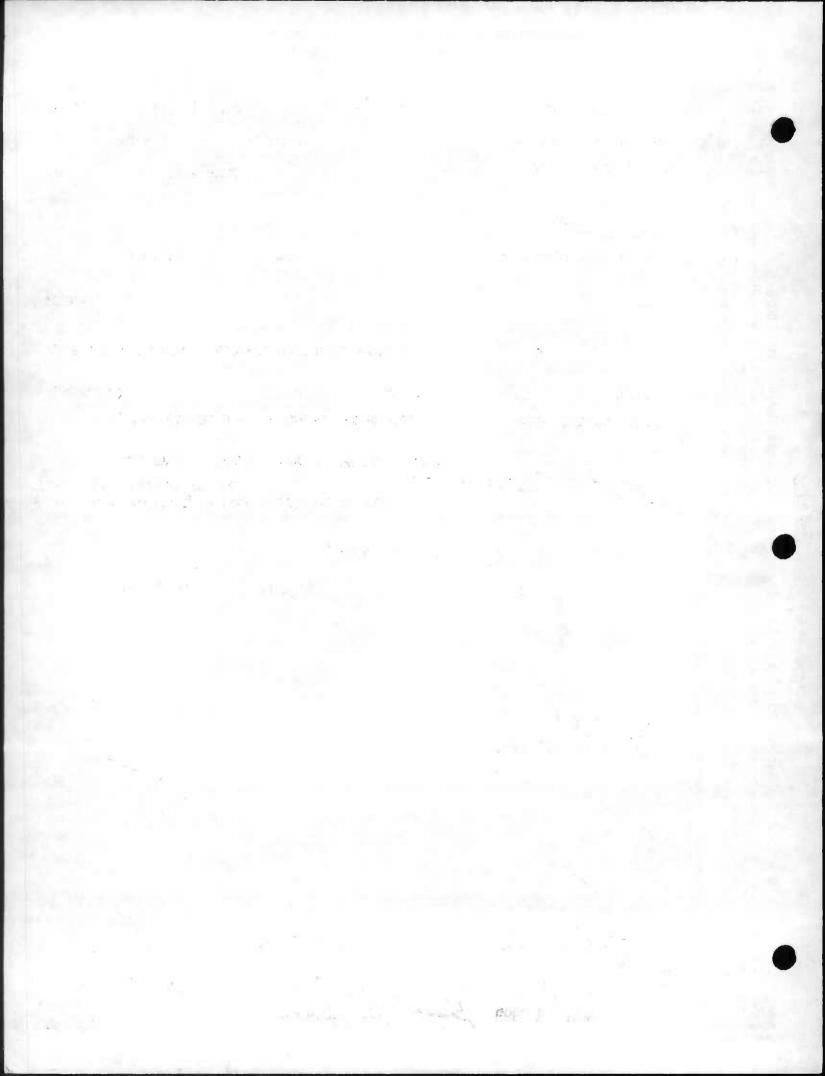
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32. Registrer Signature

20707

DHMH 16 Rev 6/95

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) APRIL 29, Dey 1999 GERTRUDE T. . FINKELSTEIN 10:55 AM 4b. City, Town, or Location of Deeth 4a Facility Nama (If not institution, give street and number) 4c. County of Deeth HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month) Days Hours Min. AUG. 1, 1915 Birthplace (Stata or Foraign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 1□M 2\ F 217-48-7598 83 Yrs. Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No ANNE ARUNDEL LAUREL 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Coda 334 GORMAN AVENUE 20707 U.S.A. 14. Race - Amarican Indien. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 11. Marital Status Black, Whita, atc. 1 ☐ Yas 2 No If Yas, Giva Year or Datas: 1 □ Navar Married 2 □ Married 1 Yas 2 No Specify: WHITE 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Dacedent's Education (Specify only highest grada complated) Elementary/Secondary (0-12) College (1-4or 5+) 12 PROPRIETOR RETAIL 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Father's Nema (First, Middle, Last) LEVIN REBECCA (UNKNOWN) 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) JAY GARY FINKELSTEIN / SON 7507 CONNECTICUT AVE. - CHEVY CHASE, MD 20815 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) BALTIMORE, MD ARLINGTON CHIZUK AMUNO 4/30/99 21. Signature of Funaral Sarvice Licansas 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat end Daath Immediata Causa (Finel disaasa or condition rasulting In death) lumonia Dua to (or as a consaquance of): Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disease or injury that initieted avants resulting in daath) Lest Dua to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was en eutopsy performed? completion of cause of daath? 2 100 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical examinar? 26. Placa of Daath (Chack only ona) Hospital: 1 Yas 2 No Othar: 4 Thursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mannas of Death 28b. Tima of 28c. Injury at Work? 1 Matural 5 Panding invastigation

physicien end the buriel-transit The lew requires that the death cartificate be axecuted Box 68760. attending p signed by the a been si certificeta hes blirector, page 2 s

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Examiner

Physician

/Medical

Examiner

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be pour another.

Physician/Medical þ Completed Be To Certification:

Examiner

Division of Vital Records, Physician: his funeral After or Attanding eftar death by the f To the Hospital or A within 24 hours efter To the Funeral Dirac completely filled in by

Medical

Registrar

29b. Signature and titla of certifian

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28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

29c. Licansa number

1 ☐ Yas 2 ☐ No

29d. Data signed (Month, Day, Yaar)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

30. Nama end addrass of parson ho completed caysa of death (Itam 23a) (Type, Print) GREGOR,

6121 Montrose Rd Rock Ville

1. Date filed (Month, Day, Year) MAY

2 ☐ Accident

3 ☐ Suicida

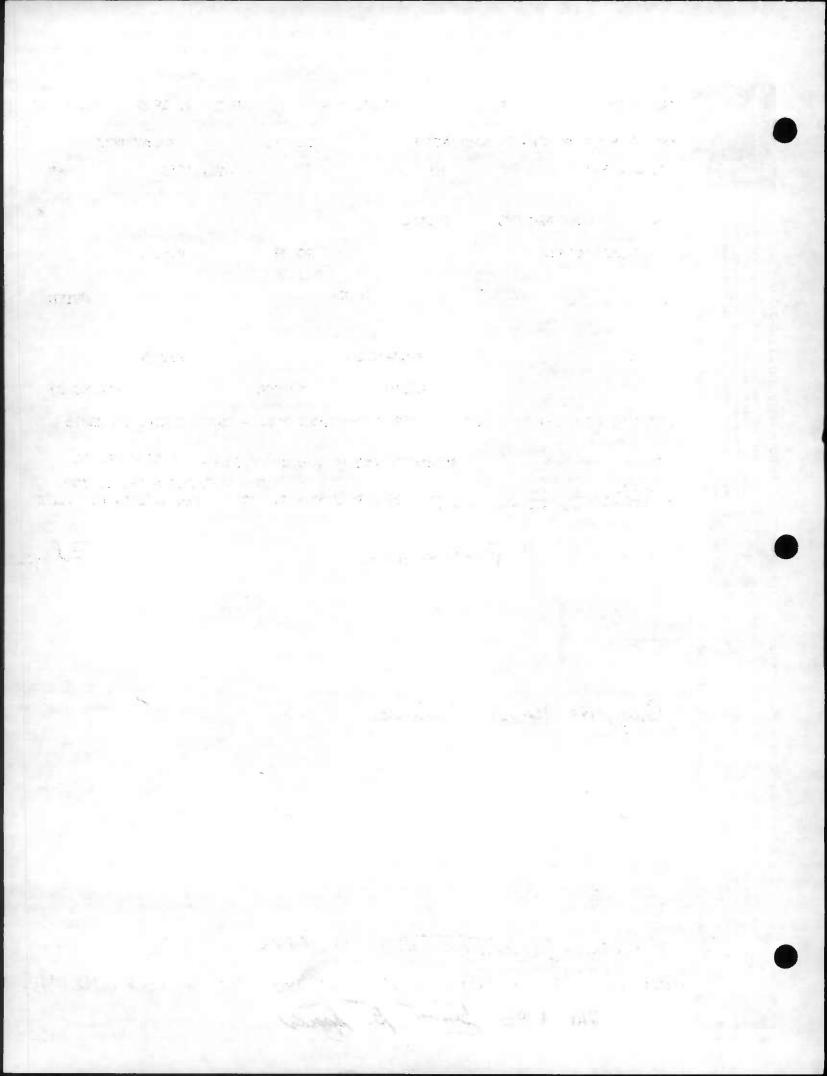
29a. Cartifian (Check only one)

4 Homicide

32. Ragistrar's Signatura

🕊 Cartifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the ceusa(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or invastigetion, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner steted.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** APRTL 30 1999 4PM ETHEL MIRIAM FRIEDMAN /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** JOHNS HOPKINS BAYVIEW HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖾 F 78 Yrs. 212-10-8862 Director PENNSYLVANIA 1920 24 Usual Rasidance of Decedant with the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits worle r than "natural", or frams 23s or 28s-f show the Medical Examiner must be notified at MD BALTIMORE BALTIMORE 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA Funeral 1205 COBB ROAD 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 2 2 No Il Yas, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, 11. Marital Status Black. Whita, atc. Peges 1 and 2 should be filed within 72 hours after nard of Health and Mental Hygiene.

INT: If Hean 27 is marked other than "natural", or the ury or other traumatte event, for a featural factoring. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🛣 No Specify: Specify:WHITE þ 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Etamentary/Secondary (0-12) Collega (1-4or 5+) MANICURIST BEAUTY 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) ABEL STERN DORA MEYER 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) PAULA B. GROVE/DAUGHTER 1205 COBB ROAD BALTIMORE MD. 21208 20a. Mathod of Disposition

1 Burial 2 Cramation 3 Ramoval from Stata 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata MIKEOV, KODESHOR BETH Department of important: If any injury or once. MAY2,99 BALTIMORE MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Paneral Service Licensee 22. Nama and Address of Facility SOL LEVINSON & BROS. INC. 23a. Pan1. Enter the disease, or complications that ceused the death. Do not an ar the mode of dying, such as cerdiac or respiratory are shock, or heart lailure. List only one cause on each line. PIKESVILLE, MD 21208 Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final ventra disaasa or condition rasulting in daath) Examiner Examiner avonen Sequantially list conditions, if any, laading to immediata ceusa. Entar Undarfying Causa (Disease or Injury that initiated evants resulting in daath) Last Dua to (or as a consequance of): The law requires that the death certificate be execu Box 68760. Physician/Medical the Dua lo (or as a consequance of): 88 for use signed by the a Part It. Other eignificant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No Division of Vital Records. Be Completed by 24b. Wara autopsy lindings available prior to 24a. Was an autopsy performed? completion of cause of death? has page 2 certificate 1 Yas 2 No 1 Yas 2 No or Attending Physicien: funerel director, 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) axaminar? Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) Certification: To 1 Yas 2 No 1 Inpatiant 2 R/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After Injury 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accidant 6 ☐ Could not be detarmined 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 I Homlcida Hospital 29a. Cartifiar 1🗹 Certifying Phyeician: To tha best ol my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 2 29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 5/1/99 rass of person who complated cause of death (ttem 23a) (Type, Print) 30. Nama and 9000

DHMH 16 Rev 6/95

State

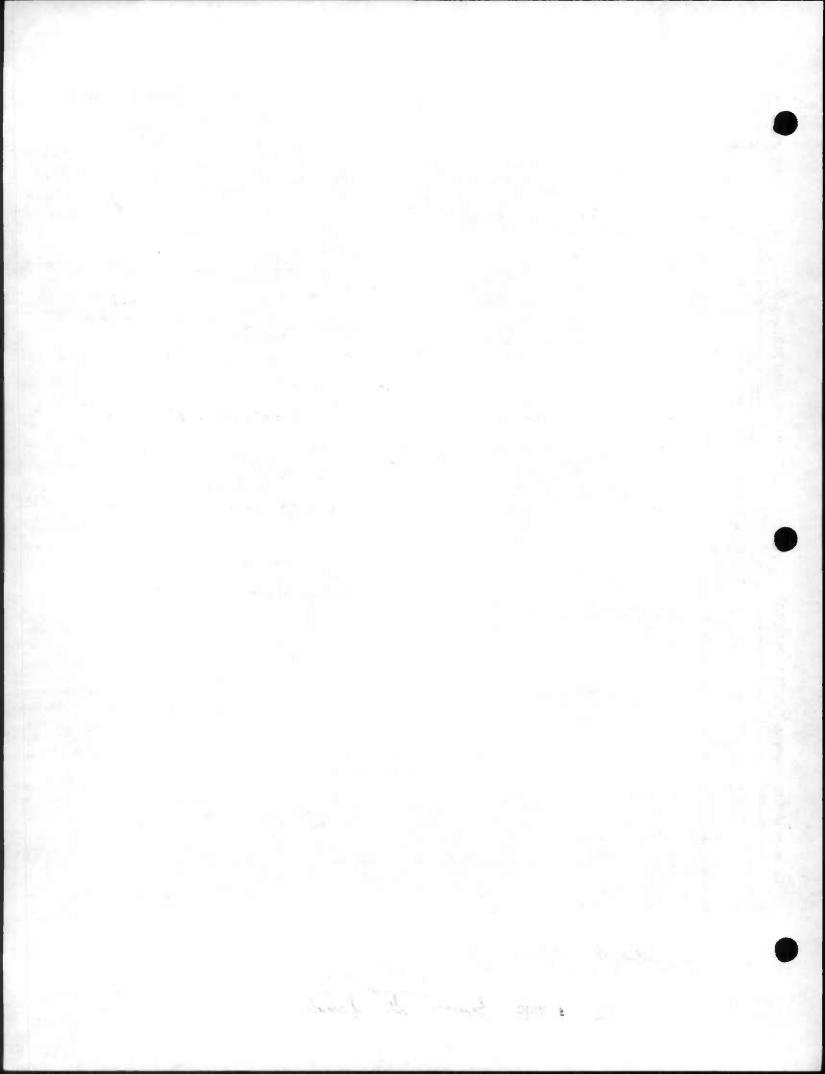
Registrar

31. Data filed (Month, Day, Year)

MAY

32. Registrar's Sign

1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Genevieve Ferrier May 3, 1999 6:30am 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 767 Old Herald Harbor Road Crownsville Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. | Aug. 23, 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 20 F 77 216-12-5500 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 ☑ No Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 767 Old Herald Harbor Road 21032 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 1 ☐ Yes 20XNo Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Cox Leona Steiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Roene Ferrier (Daughter) 767 Old Herald Harbor Road, Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Baldwin Memorial 05/05 Millersville, MD 21. Signature of Fülferal Service Lice 22. Name and Address of Fecility Hardesty Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line. 21401 **Approximete** Intervel Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) CHIF trea Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to 24e. Wes an autopsy performed? completion of cause of deeth? 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

Examiner The law requires that the death certificate be asscuted P.O. Box 68760, Physician/Medical the 60 signed by the at d be detached for Division of Vital Records, Completed by has page 2 this certificate or Attending Physician: funeral director, Be Certification: To 24 hours after death.

Funeral Director: A filled in by Hospital edicai To the Hospi within 24 hou To the Funer completely fil

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Pages 1 and 2 should be fill ment of Health and Mental H tant: If them 27 is marked oth jury or other traumatic even

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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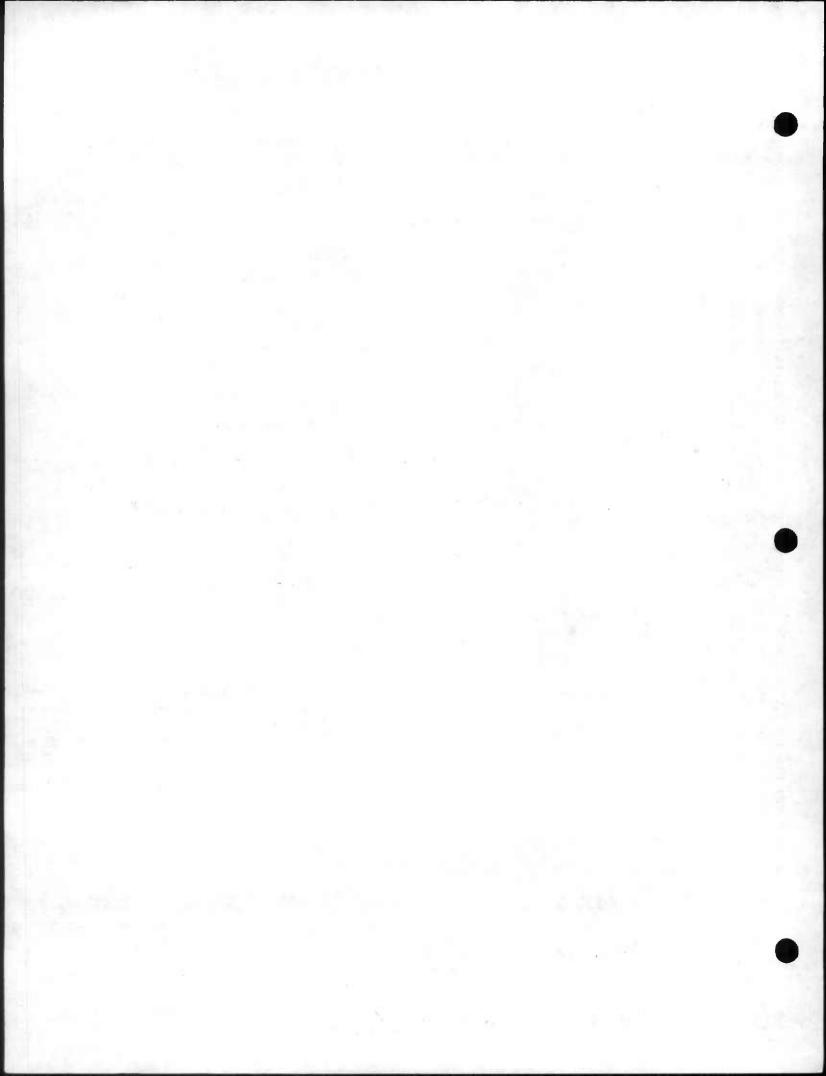
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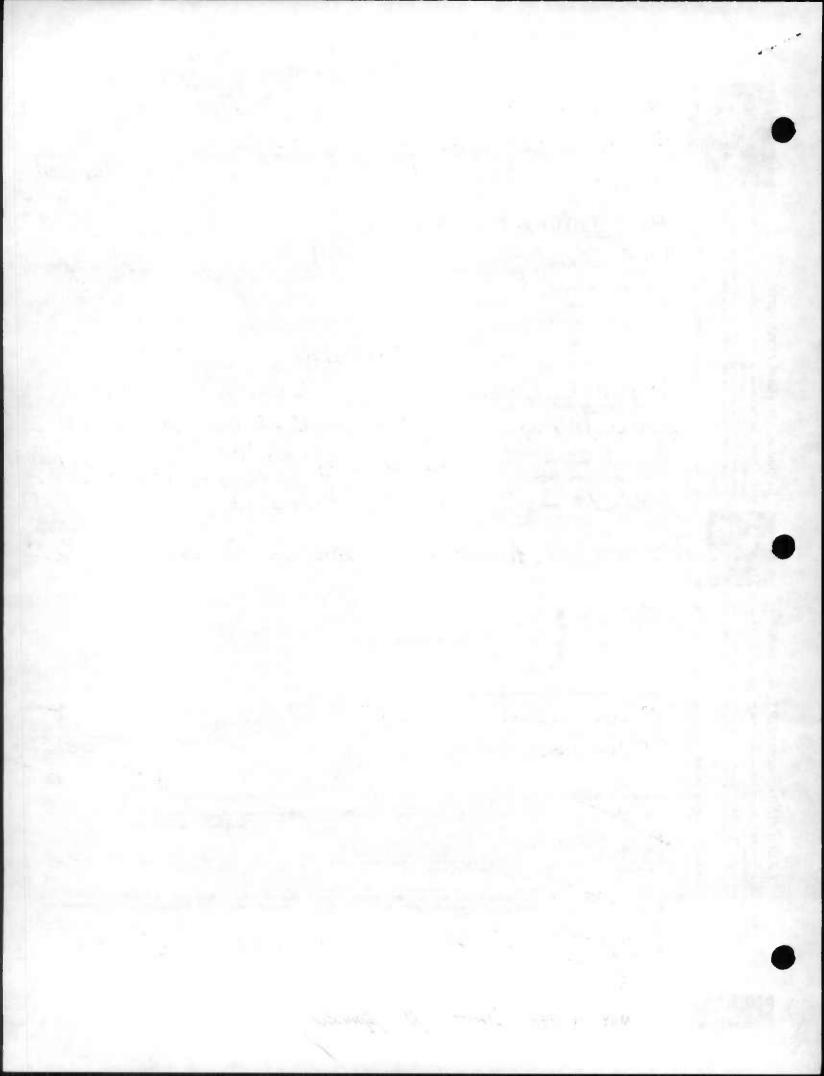
32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 4 Certificate of Death Reg. No 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MildRed :30AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not institution, give street end number, Examiner Allitage
5. Social Security Number Home If Under 1 Year 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Country)
Maryland **Funeral** Deys 10 M 200 F Months Hours MMYrs. Director Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimor 1 ☐ Yes 2 No ector Ma 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number ក់ 7 is marked other than "naturel", or items 23a or traumatic event, the Modical Examiner must be a 6104 permit. Pages 1 and 2 should be filled within 72 hours after death v Department of Health and Mental Hygiene.

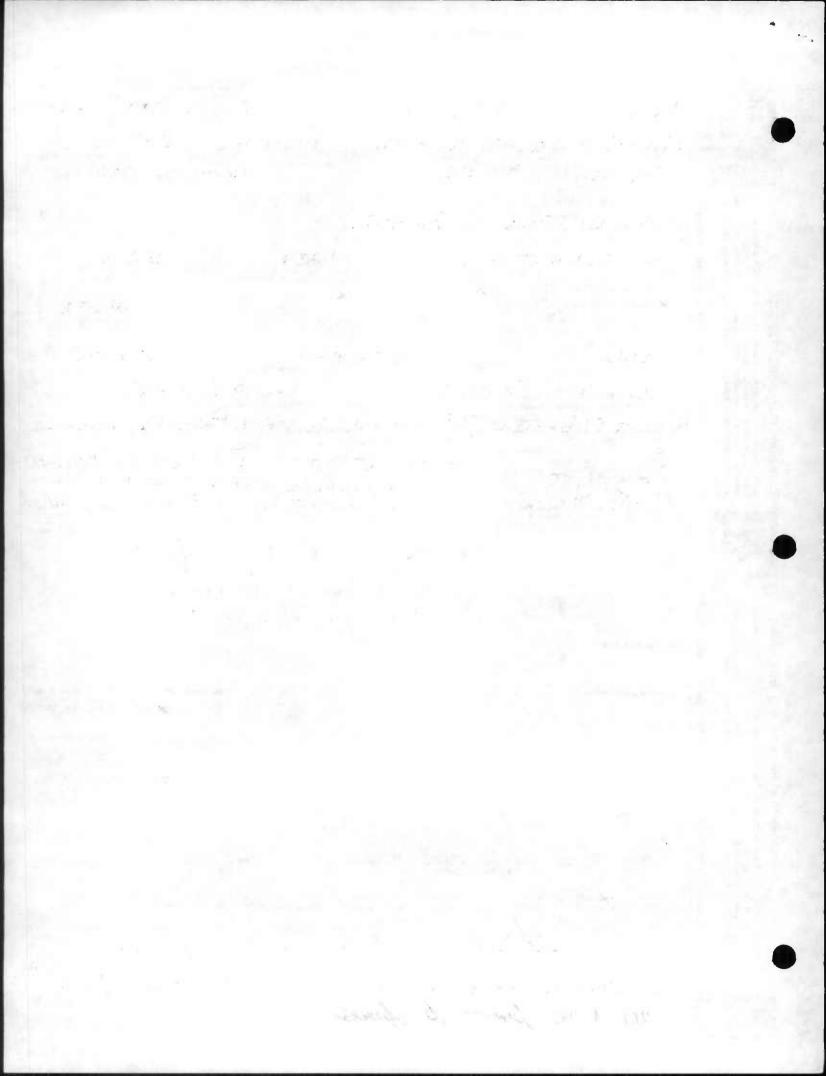
Important: If item 27 is marked other than "naturel", or items 23st and items 23st and 25s Funeral 14. Race - American Indien, Black, White, etc., 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Yes 2 No If Yes, Give Year or Dates: Specify: White 1 Never Married 2 Married 1 Yes 2 No Specify: þ 3 NWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) nomemaker nome 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be henowell JORENCE erryman To 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Monkton. 2/11/ 16104 Donne nomas 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State vans Funeral Charol-Beldie 4 ☐ Donation 5 ☐ Other (Specify) Funeral 22. Name end Address of Fecility Evans Chapel Baltimore Md 88800 Hartord 23a. Pert1/Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical VASENCAX THEROSCENORE **Examiner** Due to (or es e consequenca of). Examiner attending physician and for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): P.O. Box 68760. Physician/Medical Due to (or as e consequence of): use as 23b. Did tobacco use contribute to the cause of death? ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No signed by Division of Vital Records, þ 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed peeu hes page 2 20 No 1 Yes 1 Yes certificate To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Yeer) 28c. Injury et Work? 27, Mann 28d. Describe how injury occurred 28b. Time of Certification: 1 D Natural 2 Accident 5 Pending investigation 1 Yes 2 🗆 No 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 T Homicide 12 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and itie of certifier 29d. Date sigged (Month, Dey, Year) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 1838 ONIES 31. Dete filed (Month, Day, Year) 32. Registrer's Signature Registrar 1999 **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** MAX PPPI b: copr ATTESO GARTSIOS /Medical 4c. County of Death 4b. City, Town, or Location of Daath 4a Facility Nema (If not institution, give straet and number) Examiner If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) HOSPITAL HUNDER 1 Year BALTIMORS SQUAR 1- RAOKLIC Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days 1 □ M 250 F Yrs 220 46 1093 83 MARVLANC **Director** Usual Rasidance of Dacedant the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No BATTIMORS Directo ARKVILLS MARYLARO 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Coda tal Hygiene.
Ad other than "natural", or items 23s or event, it a Medical Examinat must be 1 with J.S.A 31334 3908 Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 14. Race - American Indian 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status Black, Whita, atc. 1 ☐ Yas 25 No If Yas, Giva Year or Datas: 1 ☐ Nevar Marriad 2 ☐ Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced TIHW Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Spacify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) AT Home 84R5-HOMEMAKER 17. Fathar'a Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Be marked BANKARU AURA Milliam 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Coda) Nem 27 I TARKYIUS ROBERT 1ARYLANG R 2408 HILLRS Baltimore, 20b. Place of Disposition (Nama of cemetary, cramatory or other place) Data 20c. Location - City or Town, State 20a. Mathod of Disposition MAYS permit. Pages Department of Important: If it any injury or o Buriai 2 ☐ Cremation 3 ☐ Ramoval from Stata Donation 5 ☐ Othar (Specify) GARDENS OF FATTH ZIA OSZOŻI 22. Nama and Address of Fecility we of Euneral Service Dicensee CHAPIL-BILATR, P.A. 3 NEWPORT ()ARASAS) DRIVE FORSTHIN VILLA 23a. Part1. Enter the disaasa, or complications in a caused the death. Do not enter the mode of dying, such es cardiac or raspiratory arrast, shock, or haart failure. List only one cause or each line. Approximata Interval Batwaan Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in daath) /Medical Examiner Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disease or Injury that initiated avants rasulting in daath) Last Ge to (or as a consequance of): Division of Vital Records, P.O. Box 68760. 260 tic C Physician/Medical Dua to (or as a consaquanca of): 88 attending p for use es signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yss 2 No 3 Probably 4 Unknown ò 24b. Wara autopsy findings available prior to completion of cause of daath? been si 24a. Was an autopsy performed? Completed is certificate has director, page 2 1 ☐ Yas 2 No Physician: 25. Was casa referred to medical axaminar? Be 26. Placa of Death (Chack only one) To Hospital: Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3□ DOA this funeral 28d. Describe how injury occurred 27. Manner of Daeth 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? Certification: After 5 Pending Invastigation or Attending 1 Naturel s after des. 1 Yas 2 No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital or A within 24 hours after To the Funeral Directory filled in b. Certifying Phyalcian: To the best of my knowledge, daath occurred et the time, data and place, and due to tha causa(s) and mannar es stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and mannar stated. 29a. Certifier Medical (Check only one) 29b. Signature and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) D37612 30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print) AGORA DRIVE AI 1201 ABRASH DAMAHO 31. Data filad (Month,-Day, Year) 32. Ragistrar's Signature State 4 1999 Registrar MAY



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath 3. Tima of Death Month 28, 1999 11:03 AM April William H. Glascoe 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE VA Maryland Health Care System If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth
Monthe Days Hours Min. 8. (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 10 M 20 F Yrs. M.D. 220-01-3338 Usual Rasidance of Decedant 10a Stata 10b. Count 10c. City, Town or Location 10d. Insida City Limits 1X Yas 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21216 U.S.A. 3615 Springdale Ave 12. Was Decedant Evar in U,S. Armed Forcas? 1 D¥yas 2 □ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Biack, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 Z No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elemantery/Secondery (0-12) College (1-4or 5+) Laborer Glidden Paint Co. 11th grade 17. Fathar's Nama (First, Middla, Last) na 18. Mothar's Nama (First, Middla, Maldan Sumama) Unknown Henry Glascoe 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Charlotte Glascoe-Wife 3615 Springdale Ave, Baltimore Md 21216 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Dothar (Specify) Garrison Forest Vet 5/4/99 Owings Mills, Md 21. Signatura of Funaral Sarvice Licansee 22. Nama and Addrass of Facility March F/H West 4300 Wabash Ave, 21215 Baltimore Md 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Deeth Immediata Causa (Final 2 Y a Renal Failure disaasa or condition Dua to (or as a consequance of): Congestive Heart Failure 2 Y Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaase or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): 2 Y Diabetes Mellitis Dua to (or as a consequance of) 1 Y Chronic Anemia Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings available prior to 24a. Was en eutopsy performed? completion of cause of death? 1 Yas 2 No 1 Yas 2 No 25. Was cesa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 Inpatiant Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Pending invastigation 1 Natural

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Physician /Medical Examiner

Examiner

Physician/Medical

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permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Meryland Department of Heelth and Mental Hyglene. Introportant: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinating to market any once.

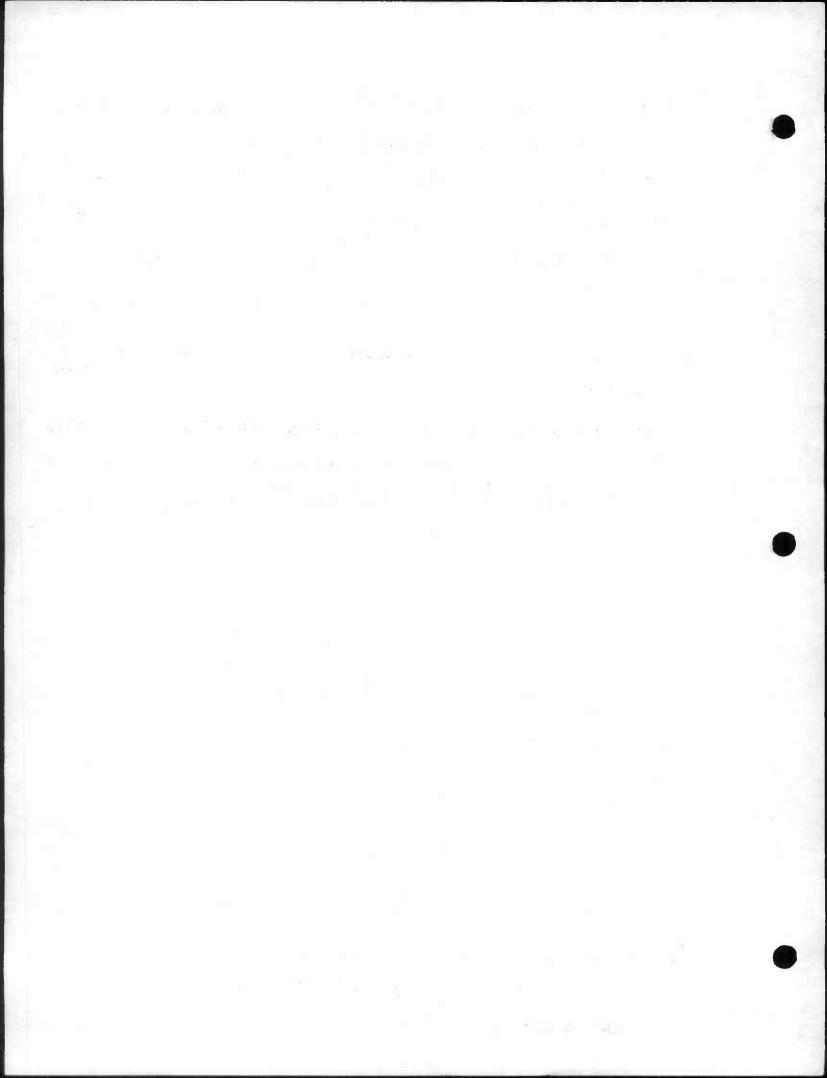
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The law requires that the deeth certificete be executed Division of Vital Records, P.O. Box 68760, After this certificate has funeral director, page 2 Hospital or Attanding Physician: i efter death.

I Director: Aff
In by the fur To the Hospital or Atta within 24 hours effected To the Funeral Directo completely filled in by the

Certification: 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 Homloida 1 Certifying Physician: To the best of my knowledge, daath occurred at tha time, date and placa, and dua to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Cartifiar (Check only 29b. Signature and title of certified 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nema and addrass of person who complated causa of death (Itam 23a) (Type, Print) Adam Clark, M.D., 10 North Greene Street, Baltimore, MD 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Day **Physician** APRIL 28, 1999 12:37PM GAITHONY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner TOWSON BALTIMORE GREATER BALTIMORE MEDICAL CENTER
Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) If Under 1 Yaar | If Under 24 Hrs. 6. Sex 1 M 2 F Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 214-82-3642 Usual Residence of Decedent 38 Yrs. Director with the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits el', or items 23a or 28a-f show Exerciner must be notified at 1 Yes 2 No NIA BALTIMORE Directo MO 10f. Zip Coda 10e. Street and Number 10g. Citizan of What Country? SYKES, ANTHONY USA 529 KIDGLY Funeral TREET med within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?/ Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yaar or Dates: 1 ☐ Yes 2 ☑ No "naturel", or Specify. Specify: by BLACK 3 Widowed 4 Divorced Completed is marked other than "natur raunwific event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) Hyglene. EMPLOYED PAINTING NIA 12 TH GRADE 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be and Mental SYKES FLETCHER BEATRICE HARDY 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) BALTO. Item 27 EARLY BROTHER 4106 MD 21215 ELDERON CLIFTON altimore. 20b. Place of Disposition (Nama of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages out of 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 5-5-99 BALTO. 4 Donation 5 Other (Specify) 4RBUTUS CEMETERY 21. Signatura of Funaral Service Licensae 22, Name and Address of Facility VAUGHN C. GREENE FUN 5151 BALTO. NATL' PIKE, FUNERAL SERVICE IKE, BALTO. MO. 23a. Part1. Enter the disease, or complications that ceusad tha death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or hear-failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical CRYPTOCOCLAL PHENMONIA WEEKS Examiner Due to (or as a consequence of) Examine 5 WEEKS PNEHMOLYSTIS CARINIZ PNEUMONZA The law requires that the death certificate be executed physicien end the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ACQUERED WEEKS IMMUNU DEFICZIENCY SYNDROME Physician/Medicai that initiated avents resulting in deeth) Last Dua to (or as a consequence of): ettending ph by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown g been sign 24e. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? certificate hes b 2 X No 1 Yes 1 Yes 2 No or Attending Physician: director, 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 2 1 Yes 2 No 12 Inpatient 2 ER/Outpatient 3 DOA this 28e. Date of Injury (Month, Dey Year) funeral 28d. Describe how Injury occurred 27. Manger of Death 28b Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending To the Hospital or Attending within 24 hours efter death.

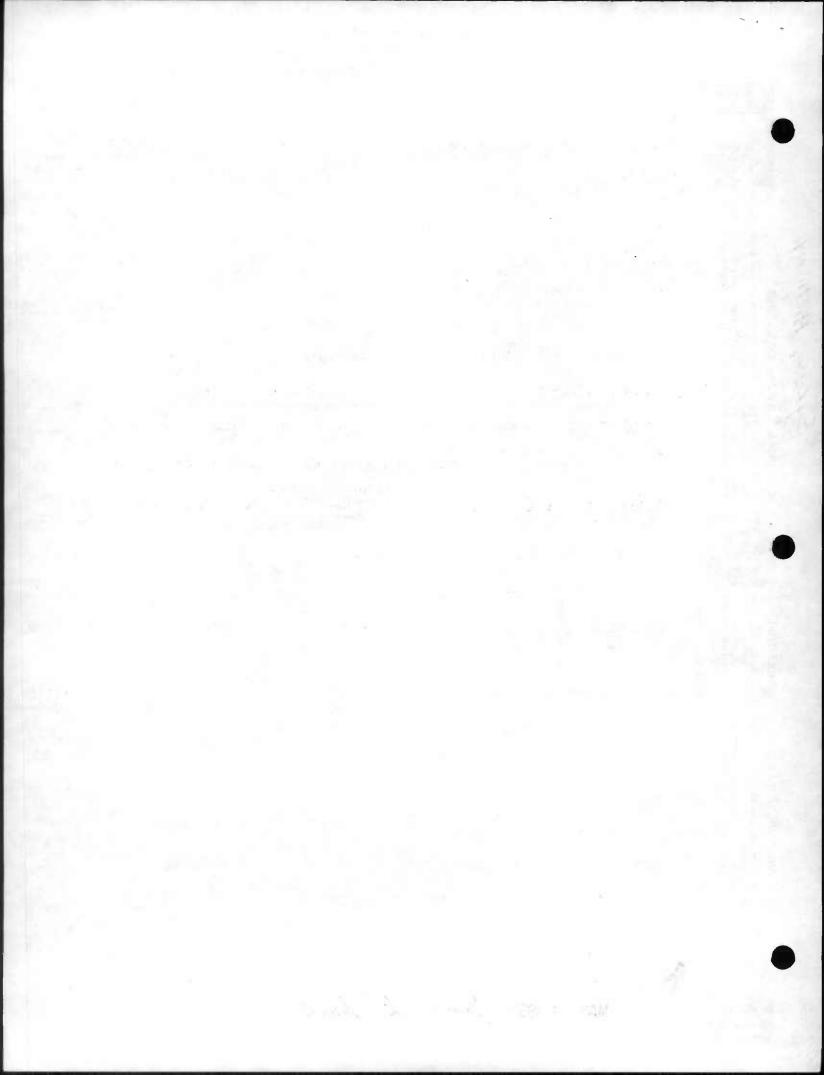
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Hornicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated. edical 2 Medical Examiner: On the basis of examinetion and/or Investigation, In my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 1999 053430 APRIL 29 30. Name and addrass of person who completed ceuse of death (Item 23a) (Type, Print) CHAN 6701 NOKTH CHARLES STREET BALTZMORE MARYLAND 21204

32. Registrar's Signature

1999

Registrar

State



10d. Inside City Limits 1 Yas 2 No

 Birthplace (Stata or Foreign Country) Maryland

	ITEM: #	PER F.H. G770	5-04-99 W		of Maryla		epartme Certifica			and M	ental Hy	/giene	99	14	1422		
		1. Decedent's Nama	(First, Middle, Las)							2. Data of Death			Vere	3. Time of Death		
	Physician /Medical	Herne1	-3.10.25	К.	K. Gruber						Month APRII	-		Year 999	8:35 PM		
	Examiner	4a Facility Nama (If r									cation of Dea	th 4c	. County	of Death			
					Medical Center					Towson				Baltimore			
	Funeral	5. Social Security Number 6.		V		Months [er 1 Year Days	If Under	24 Hrs. Min.	8. Data of Bi	Birth 1919 9. Bi		9. Birth	Birthplace (Stata or Foreig Country)		
	Director	220-05-611	EM ZUF	80	Yn	S				pril	17,4	1999		y1and			
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	death with the Menyland ms 23a or 28a-f show Linuis be notified at neral Director	10a. Stata	re	100.0		Timonium								10d. Inside City Limit			
	vith the Me tor 28a-fa be notified	10e. Street and Numb				TIMO	10f. Zip Code						10g. Citizen of What Countr		ntry?		
	A D	2200 P 3		11. n	. 1				002								
~	era era	11. Marital Status	Laney Va	12 Was Dec	redent Ever in	US	13 Was Dec		1093			USA USA			marican Indian,		
020	020 urs after it, or its Exercise	1 Never Married 3 □ Widowed 4	Armed Fi	Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates:			 Was Decedent of Hispanic Origin? (Spec if Yes, specify Cuban, Mexican, Puerto R □ Yes 2X No Specify: 				Rican, etc.) Black,		White, etc.				
0		1	ucation		ecedent's Us	edent's Usual Occupation				16b. Kind		ind of Businass/Industry					
25	ed within 72 ho yglene. • Than "natural, it, the Medical Completed		only highest grad			- (C	(Give kind of work done during most of work life. DO NOT use retired)					king Balti			imore City Dept.		
200	the the	Elementary/Second	Jany (U-12)	N/A	(1-4or 5+)	Admi	Administrative			Officer			Hea]	th			
D	be filed Hyge a other avent,	17. Father's Nama (Fi	irst, Middle, Last)					18. Mother's N			(First, Middle						
yian	Mental Mental aric av	Grayson N	Martin G	ruber	uber					Vada Kiracofe							
a	end end	19a. Informent's Nam	ne/Ralationship (7	ype, Print)		19b. N	Aeiling Addre	ss (Street	and Numbe	or Or Rura	l Route Numi	ber, City	or Town,	Stete, Zip	Code)		
2	alth 27	Richard E.	Troy/Gu	uardian	1	103	Gorsu	ch R	oad T:	imoni	Lum, MI	210	93				
S e	I se life in the se l	20a. Mathod of Disposition 20b. Place of Disposition (Name of Data 20c. Location - City or Town, Stata															
E	Page net: If iny or	1 Burial 2 Micromation 3 Removal from Stata Baltimore Washington (Crematory) 4 Donation 5 Other (Specify) Baltimore Washington (1999 Laurel, MD)															
Baitimore, Maryland	permit. Pages 1 end 2 should be filed within 7 Department of Health end Mental Hyglene. Important: If Item 27 is marked other than "reany injury or other traumatic avant, the Medants.	21. Signature of Fund	2	Flagie)		22. Name a Lemmon	Fun		lome	of Dul				Inc.		
	Physician	23a. Part1. Enter the shock, or heart											וט צו	-	Approximata Interval Between Onset and Death		
	/Medical Examiner	Immediate Causa (Fi diseasa or condition resulting in death)	PNEUMONIA										!	4 DAYS			
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, P.O.	ed by the detacher	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. DEMENTIA									23b. Did tobecco use contribute to the cause of de				1		
Records,	been should										24a. Was an autopsy performed?			av cc	rara eutopsy findings vailable prior to empletion of cause death?		
	yaician: The law is certificate has director, page 2 To Be Comp										10	Yes 2	X No		□Yas 2⊠No		
Vitai	certificate rector, pag	25. Was casa refarred	d to medical	, 111					26. Place	of Death	(Check only	one)					
	Physician: this certific ral director, To Be	axaminer? 1 ☐ Yes 2 ☐ No	0	Hospital:	Inpatient 2[☐ ER/Outpa	atient 3 🗆 E	Oth Oth	ner: 4□ Nu	rsing Hor	na 5□Res	idence	8 DOthe	er (Speci	(y)		
on of	5 5 8		5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Tima of User. Injury et Work?						12	28d. Describe how injury occurred						
Division	or Attending P after death. Director: After I In by the funer ertification:	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	28e. Place	e of Injury - At ling, etc. (Spec	homa, farm					28f. Location City or To	(Street a	nd Numb e)	er or Run	al Routa Number,		

1 Neturel
2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the bests of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year)

D41410

m.0 h 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

JOGINDER P. MEHTA. 7601 M. D. . OSLER DRIVE, TOWSON, MARYLAND 21204 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

State Registrar

Certification:

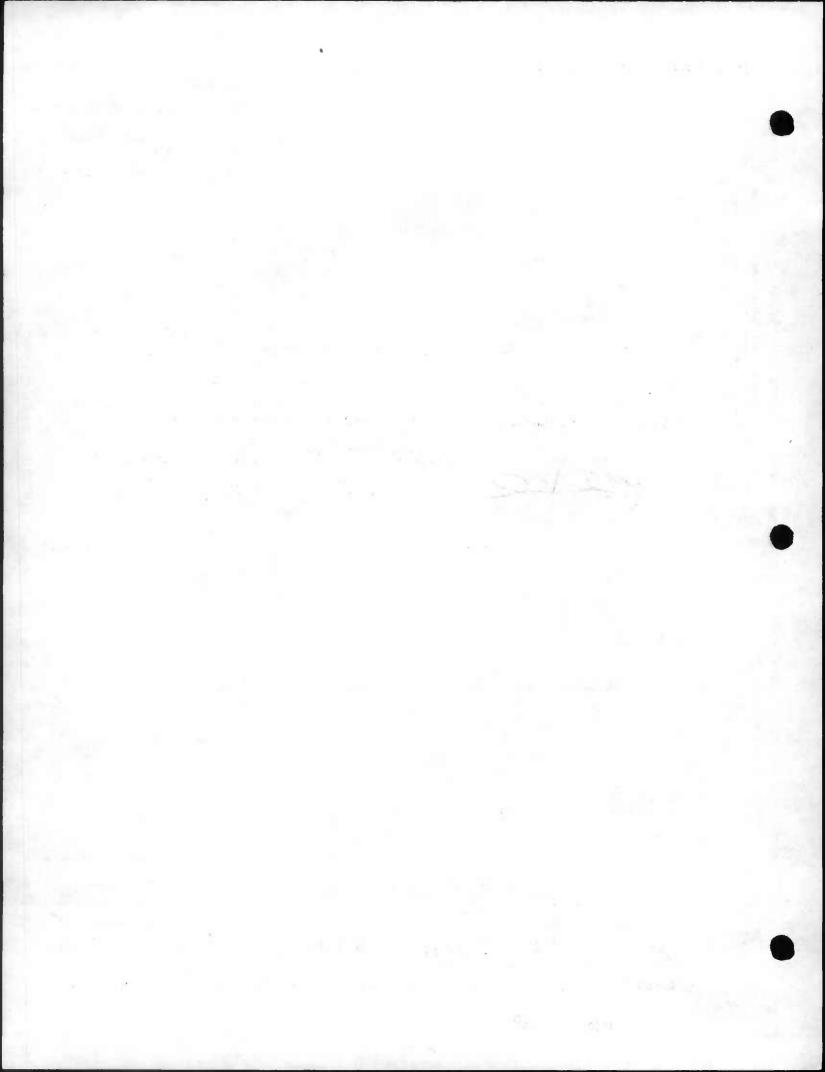
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filled in by

tal or Attanding Physician: This after death.

Fal Director: After this certificate in by the funeral director, pa

To the Mospital of within 24 hours at To the Funeral Dicompletely filled it



Piease Type or Print in Biack Indelible Ink. Assure Aii Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Dev Month Year Stefanie Gish 29 1999 4c. County of Deeth 4b. City, Town, or Location of Deeth 2:36pm 4a Facility Nama (If not institution, giva street and number) Johns Hopkins Bayview Medical Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 8.7 Yrs. Months Days Hours Min. Nov. 22, 191 5. Sociel Security Number Birthplace (State or Foreign Country) 1□M 2X F 219-40-9114 Md. Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore 1 ☐ Yes ¾ ☐ No Dundalk 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 103 Center Place Apt. 226 21222 USA 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, apecify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indien, Bleck, White, atc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) 5 yrs. College (1-4or 5+) Home yrs. Housewife. 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Andrew Jansinski Anna Jansinski 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Antoinette Pruss 302 E. Joppa Rd. Towson Md. 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cremetion 3 ☐ Removei from State Sacred Heart of Jesus 5 - 3Dundalk 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice License 22. Neme end Address of Fecility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Part. Enter the disease for complications that caused the contin. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediata Ceuse (Final · Recurrent massive right pleural effusion 6 days disaasa or condition rasulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Last Due to (or es a consequence of): Due to (or es e consequence of):

Physician/Medical Examiner ettending physician and lor use as the buriel-transit The lew requires that the deeth certificete be executed Division of Vital Records, P.O. Box 68760, signed by the e þ Completed Be

To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the luneral director, p. Certification: To Medical

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29b. Signatura and title of certifier

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

Peges 1 and 2 should be filed within 72 hours efter ment of Health and Mentel Hygiene.

Antel file and 71 la marked other than "natural", or file may or other traumate avent, the Mentel Earning my or other traumate avent, the Mentel at Earning

Department of Important: If any injury or page.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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the Maryland

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Atmal fibriation		23b. Did tobacco use contribute to the cause of death' 1 Yes 2 No 3 Probably 4 Unknow					
				24a. Was en eutopsy performed?	24b. Were autopsy tindinga aveilable prior to completion of cause of death?		
25. Wes case reterred to medical examiner?			eath (Check only one)				
1 Yes 2 No	Hospitel: 1 Inpatient 2[☐ ER/Outpatient 3☐ I	OOA Other: 4 Nursing	Home 5 ☐ Residenca 6 ☐ Ott	ner (Specify)		
27. Manner of Deeth 1 Neturel 5 □ Pending 2 □ Accident investigatio		28b. Tima of Injury M	28d. Describe how injury occur	rred			
3 Suicida 6 Could not b 4 Homicide datermined		home, ferm, atreet, fectorify)	28f. Location (Street and Number or Rural Routa Number, City or Town, State)				
				e, and dua to tha causa(s) end murred at the time, data and placa,			

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

maurier RHoston

Horton Johns Hopkins Bayview Medical Center m.D. Maureen 31. Date tiled (Month, Day, Year)

29c. License number

047950

29d. Date signed (Month, Day, Year)

29,1999

State Registrar 32. Registrer's Signetura souks

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State Registrar

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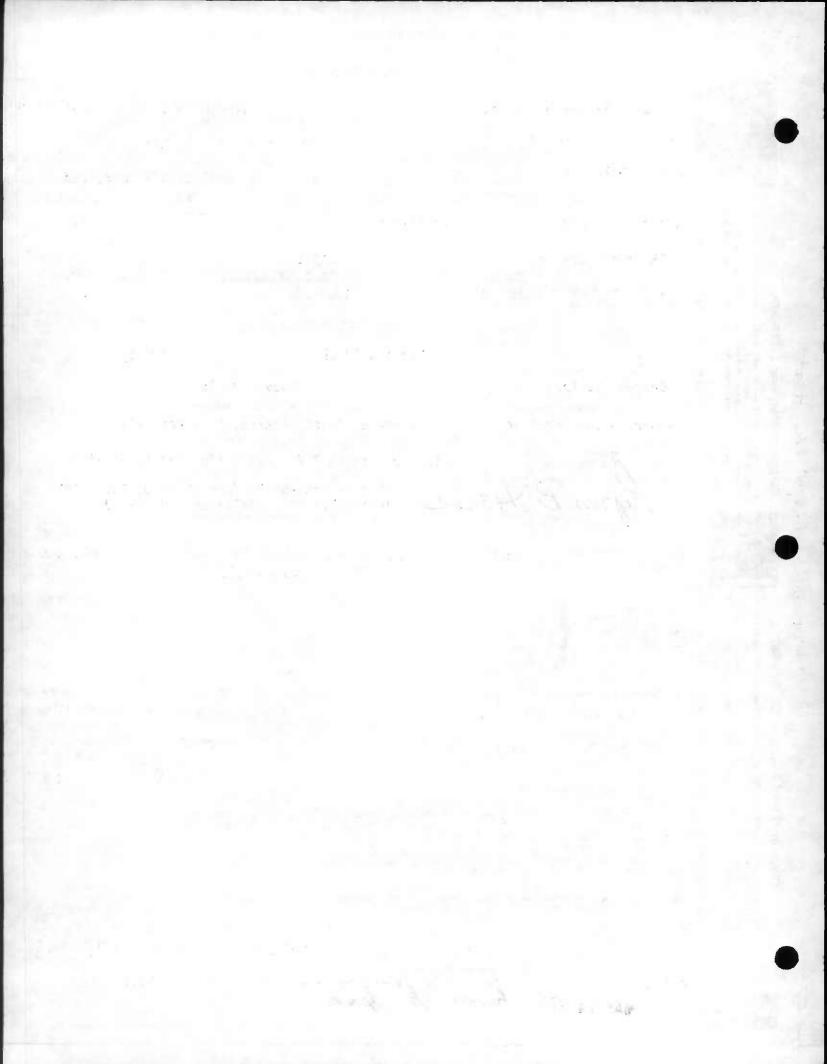
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Death 1. Decedant's Name (First, Middle, Last) **Physician** 0205 PM 1999 Carroll Lee Hart, Jr. APRIL · /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 2□ F 213-30-9123 Yrs **Director** April 22,1933 Maryland 66 Usual Residence of Dacedani the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits itam 27 is marked other than "natural", or itema 23a or 28a-f ahow other traumatic event, the Modical Examinar must be notified at Yes 2 No Directo Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2268 Druid Park Drive 21211 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Yes 2 VNo If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White Baltimore, Maryland 21215-0020 à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) 12 should be filed within 72 h end Mental Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) Loading Trucks Newspaper 17. Fether's Neme (First, Middle, Last) Land Lee Hart 18. Mother's Name (First, Middle, Maiden Surname) Be Gladys Miller Carroll L. Hart, Sr. 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Depertment of Health enc Important: If itam 27 is in any injury or other traun once. Richard Joyce Brother 1 Quaker Court, Sparks, Maryland 21152 20b. Plece of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Balto. Washingtony 4/30/99 Laurel, Maryland 21. Signature of Fynaral Service Line 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each lina. Approximate Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) NON-SMALL CELL CARCINOMA OF THE LUNG, UNKNOWN Examiner STAGE IV Due to (or as a consequence of): Examiner ician end burial-transit Sequentially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Disease or injury Due to (or as a consequence of) physician the buna Physician/Medical thet Initiated events resulting in death) Last Due to (or as a consequence of) use as 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown CHRONIC EMPYEMA by Division of Vital Records, 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed SCHIZO PHRENIA completion of cause of death? page 2 has 1 Yes 2 No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examinar? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of Certification: 28c. Injury at Work? 5 Pending investigation 1 MNatural s efter death. 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours Hospital 12 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basic of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifiai (Check only one) within 2 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier HOUSE APRIL 27, 1999 D0052122 OFFICER 30. Name end addrass of P. J. A.C.KSOK person who completed cause of death (Item 23a) (Type, Print) 2401 W. BELLER AVE, BALTIMORE, MD BOOTH

DHMH 16 Rev 6/95

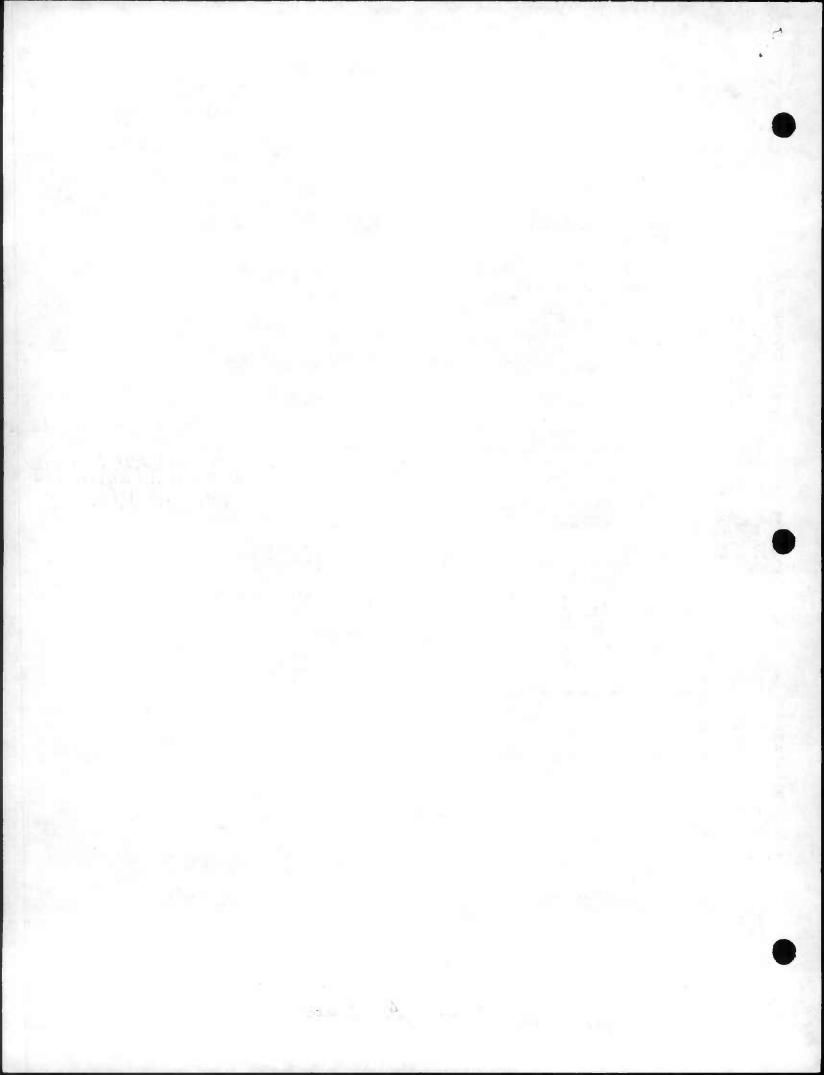
State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Joseph Hoeck 3:33 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death LISTON Harford If Under 24 Hrs. Hospital 9. Birthplace (State or Foreign Country) H Under 1 Year 5. Social Security Number 6. Sex 7. Apd (In yrs. last birthday) Funeral Months Days 48 10M 20F Yrs. Maeyland Director with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 Yes 2 No Rfor Director M_{o} 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21050 Funeral 14. Raca - Amarican Indian, Bleck, White, etc. | Nema Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12 Was Decedent Ever in U,S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: the Medical Examiner filed within 72 hours after 1 Never Married 2 Married Specify: White 21215-0020 8 1 Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced natural'. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Heathcake Advanced I Hygiene. entary/Secondary (0-12) College (1-4or 5+) payable manager .. Pages 1 and 2 should be filed w tment of Health end Mental Hygler tant: If Item 27 Is marked other to jury or other traumatic event, to 10 Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle, Maiden Sumeme) B Mildred HOPCK 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) YOPC Idia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 Removal trom Stete Department of Important: If any Injury or once. 4 Donation 5 □Other (Specify) Memorial Gar 22. Nama and Address of Fecility EVANS 21. Signature of Funeral Service Licensee Funeral Chasel r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, part feilure. List only one cause on each line. 21050 Approximata Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finet disease or condition resulting in death) urravalla Examiner Examiner The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): signed by the ettending p Part tl. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy tindings eveilable prior to complation of causa of death? 24a. Wes en autopsy performed? page 2 should this cartificate has 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Attending Physician: funaral director, Be 25. Was case referred to medicat axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 TYes 20€ No 1 Inpatient 2 TER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending investigation 1 Matural efter deeth. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of tnjury - At home, term, street, tectory, office building, etc. (Specify) filled in by 4 Homicide 8 To the Hospital of within 24 hours of To the Funeral D 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) 36487 mo nd addre s of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **DHMH 16 Rev 6/95**

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The law requires that the daath certificate be executed Division of Vital Records, P.O. Box 68760, Physician: or Attanding deeth. within 24 hours after deeth To the Funeral Director: / complately filled in by the f To the To the To the

Physician

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Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with 8 Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23s or 2 any injury or other treumstic event, the Medical Examiner must be mone.

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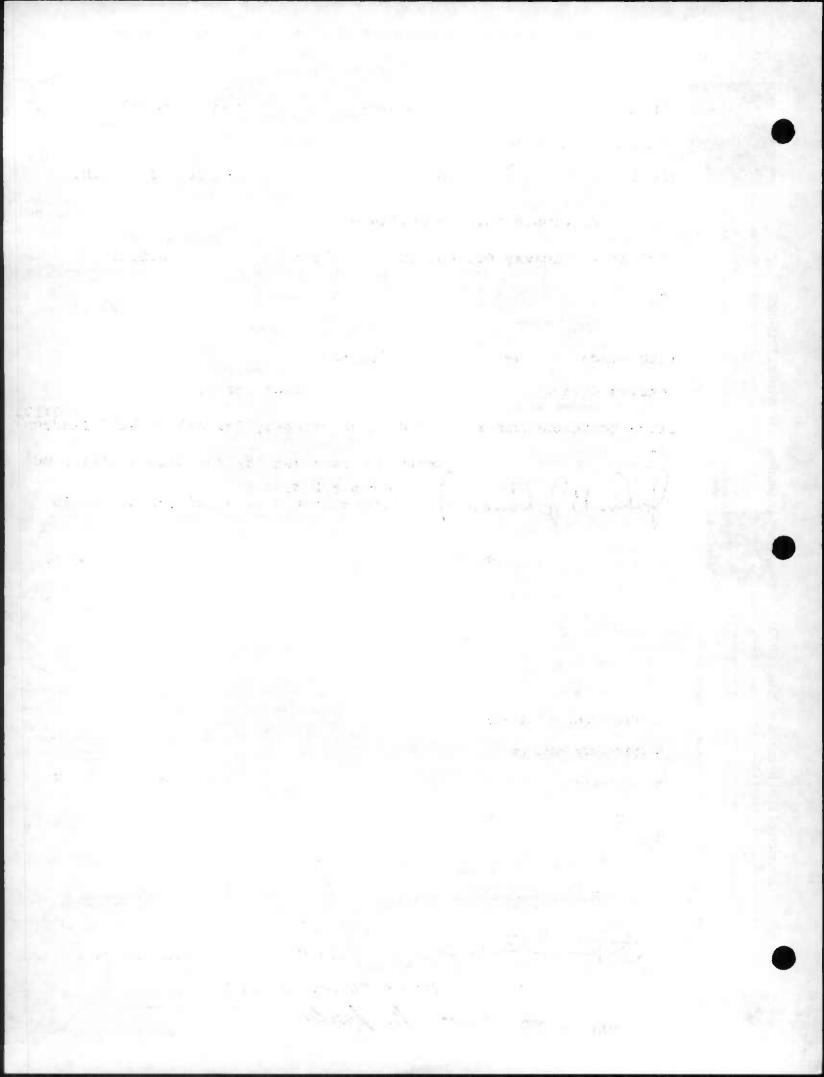
30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

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N. Wolfe Street-Baltimore, Md. 21287 32. Registrar's Signature

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April 29, 1999



certificate be executed Division of Vital Records, P.O. Box 68760,

ettending physicien end for use es the buriel-transit ed by the e this funeral Hospital or Attending death. ofter death Director: 24 hours

Funeral

Director

s: end 2 should be filed within 72 hours efter death with the Menylen if Health end Mental Hygiene. It health end Sa or 28a-f show other traumatic event, Tre Medical Examiner man be notified at

Pages ment of t

Physician

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Certification: þ 29a. Certifier To the Hosp within 24 hou To the Fune completely fil edlcai

> State Registrar

29b. Signature end title of certifier Jan un

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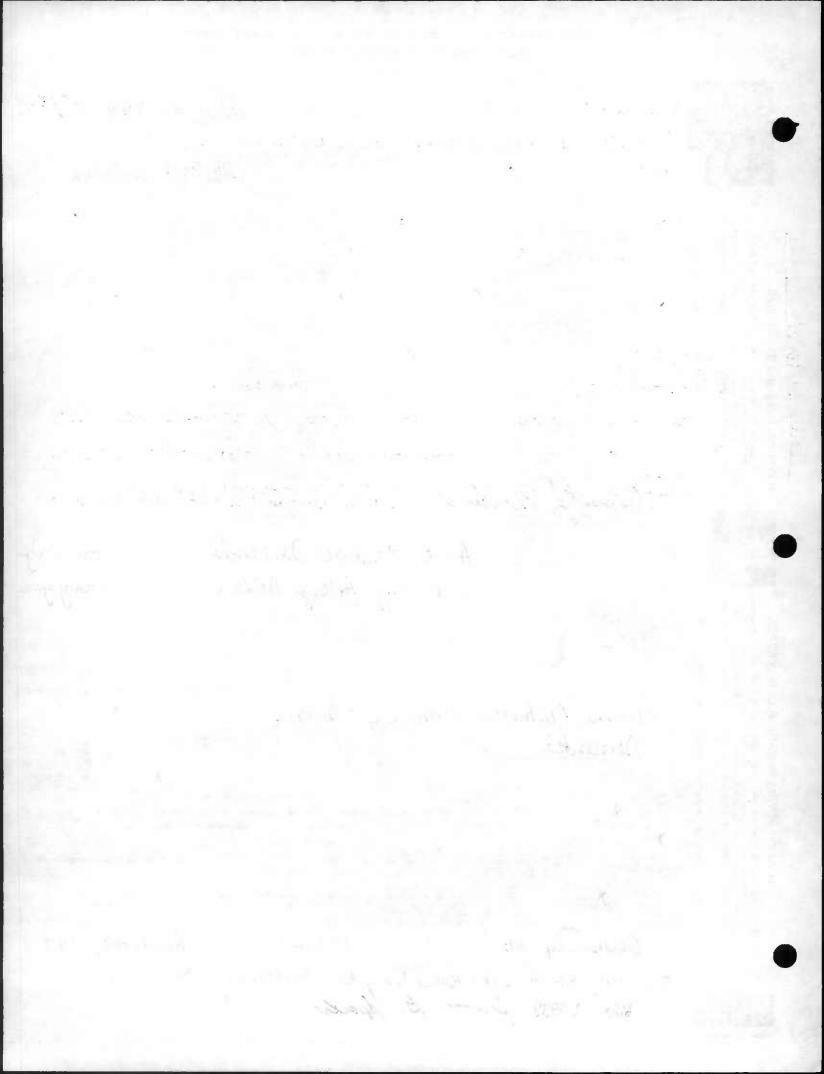
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1 Certifying Physicfen: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) and menner stated. 29d. Date signed (Month, Day, Year) April 29, 1999

30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print) 4367 Holling Fengy Rd, Bultinous. RAJA

32 Registrer's Signature



d cause of death (Item 23a) (Type, Print) and

32. Registrar's Signeture

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Registrar **DHMH 16 Rev 6/95**

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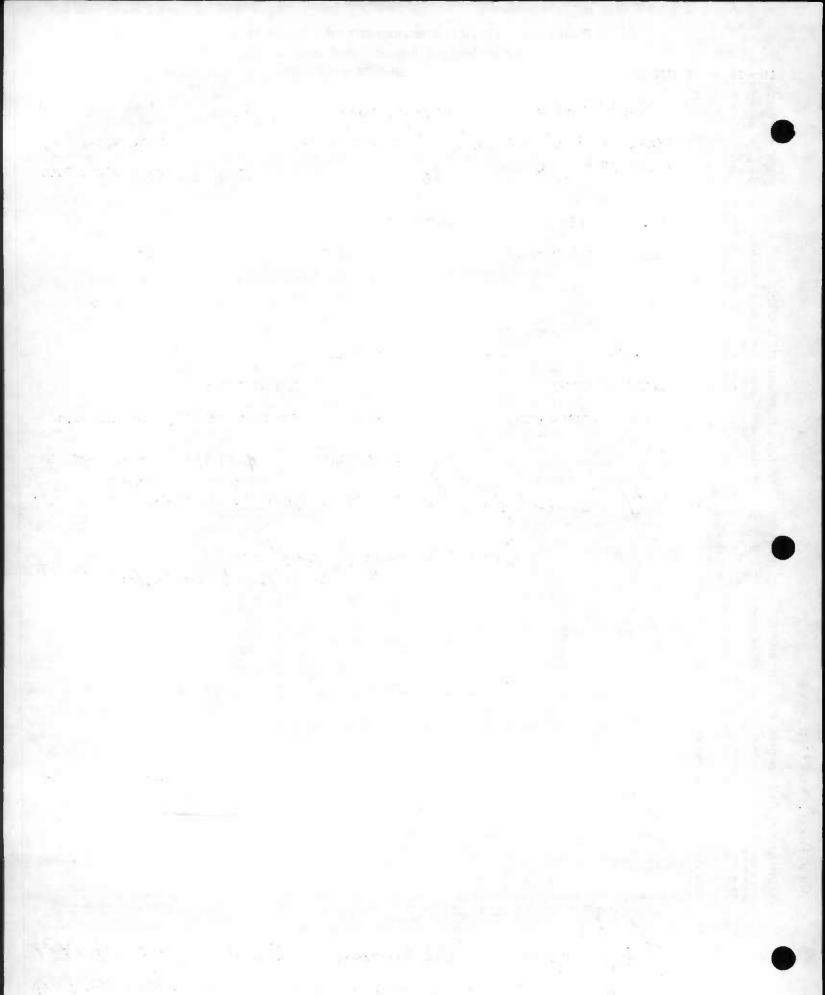
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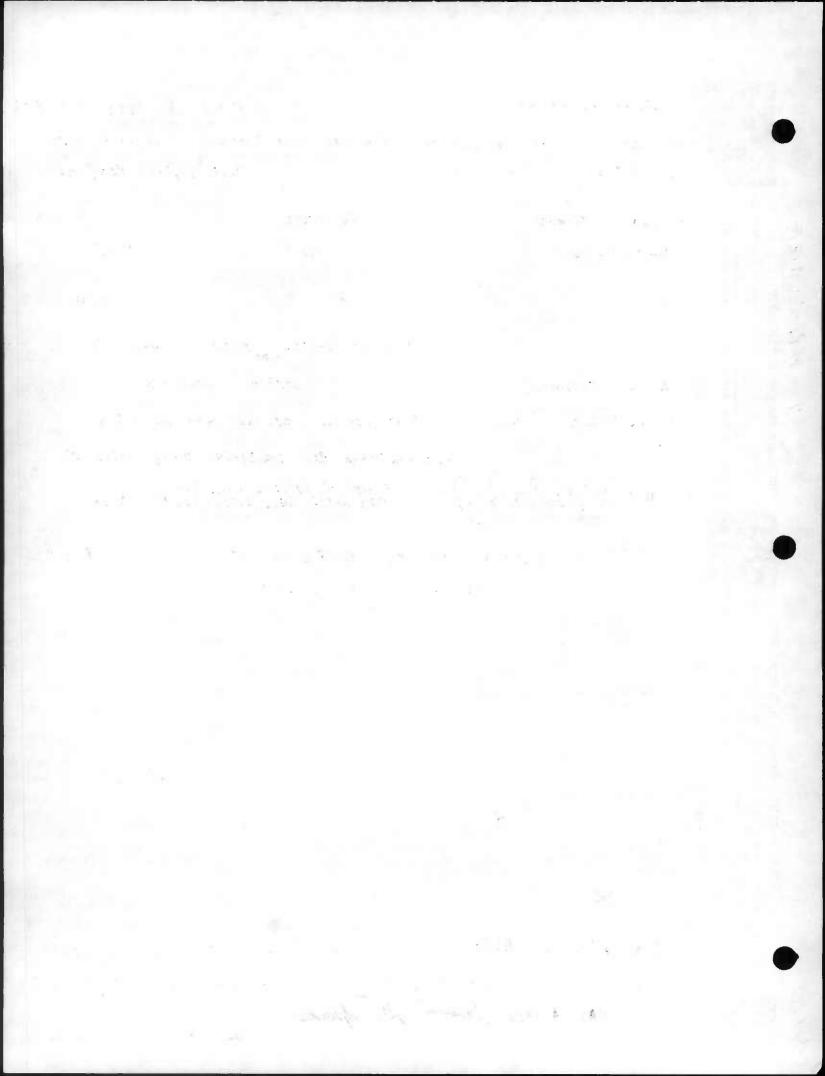
		Certificate of	Death		. No.		
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ceatte K. 1100				MAY	-		0:19 P
4a Fecility Neme (If not institution, give s			4b. City, Town, or Loc		4c. County		
FRANKLIN SOUAL 5. Social Security Number 212-20-2336 Usuel Residence of Decedent	7. Age (In yrs. le	est birthday) If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y. Sept. 13	,1924	9. Birthplece Country) Maryle	(State or For
10a. State 10b. County Maryland Baltimore		Town or Location Balt	imore				nside City Lin
10e. Street end Number 5400 Balistan Roo		10f. Zip Code	21237	10g		Thet Country?	
11. Merital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	2. Wes Decedent Ever in U,S Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Specien, Mexicen, Puerto F	cify Yes or No- Rican, etc.)		e - American In- k, White, etc.	
15. Decedent's Educ (Specify only highest grede		16e. Decedent's Usual Occu	pation during most of working	16	b. Kind of Bu	siness/Industry	,
Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retin Executive As	sistant to	the	Unive	ersity	
17. Father's Name (First, Middle, Last) Albert Oldenbw	rg		18. Mother's Name Nellie	(First, Middle, Me McDo		Θ)	
19e. informent's Neme/Reletionship (Type Ann C. Anthony	oe, Print) (daughter)	19b. Malling Address (Stree 9013 Transon				Stete, Zip Code 21236	9)
20a. Method of Disposition 1 ABurial 2 Cremation 3 Re 4 Donetion 5 Other (Specify)	emovel from State 20b. Pla	ace of Disposition (Neme of metery, cremetory or other plants rison Forest	ace)	Dete 20	c. Location -	City or Town, S Mills,	
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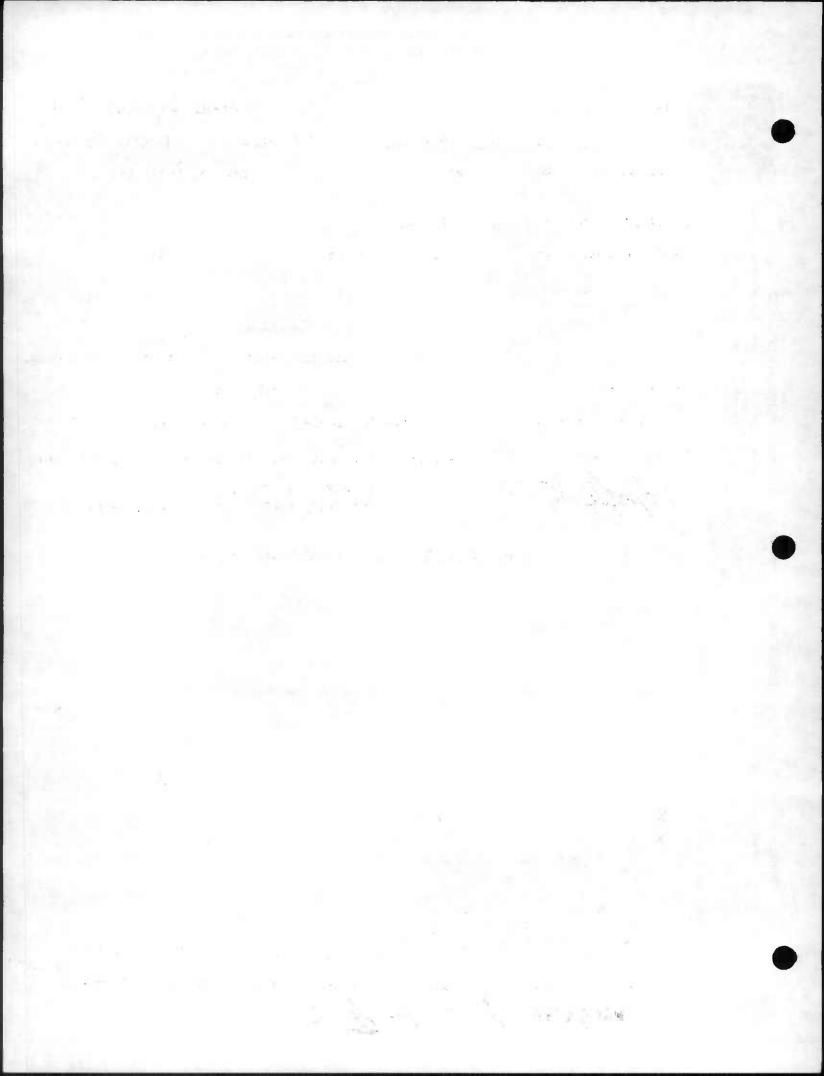
30. Name entaddress of person who completed cause of deeth (Item 23e) (Type, Print)

SUZAMFE PASTORE ND, 9000 FRANKLIN SQ DR. BALTO, ND 21237 SUZAMPE.
31. Dete filed (Month, Dey, Year) MAY



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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o Mar	yland	Pri	nce	George		Laur	۵1							1□ Yes 2√ No
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 KATHERINE Month HANSON 0140 4a Fecility Name (If not institution, give street end number) ANNE ANUNIEL MEN 4b. City, Town, or Location of Death 4c. County of Death ANNAPOUS ANNE If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Months Deys 1□ M 3€ F Hours 78 214-16-5997 July 15, 1920 Virginia Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits Yes 2 No Anne Arundel Annapolis 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3047 Aberdeen Road TISA 21403 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 12. Was Decadent Ever in U,S. Armed Forces? 11. Maritai Status 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married 1□ Yes ZH No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) George William Hickman Myrtle T. Colson 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Norris M. Hanson (Husband) 3047 Aberdeen Road, Annapolis, MD 21403 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Buriel 2 Cremation 3 Remove from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial Gardens 05/05 Davidsonville, MD 21. Signature of Eugeral Service Licanse 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeti Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) HTW Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident

Box 68760. Division of Vital Records, P.O. Physician: or Attending daath.

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Physician

/Medical

Examiner

Funeral

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Certification:

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3 Suicide

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Maryland 21215-0020

Baltimore,

within 24 hours at To the Funeral D completely filled I To the

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier, 21438

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

DUE STE 120 ANNAPULY Md 21401

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

6 Could not be determined

See 4 1999 - --- PREL & YA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

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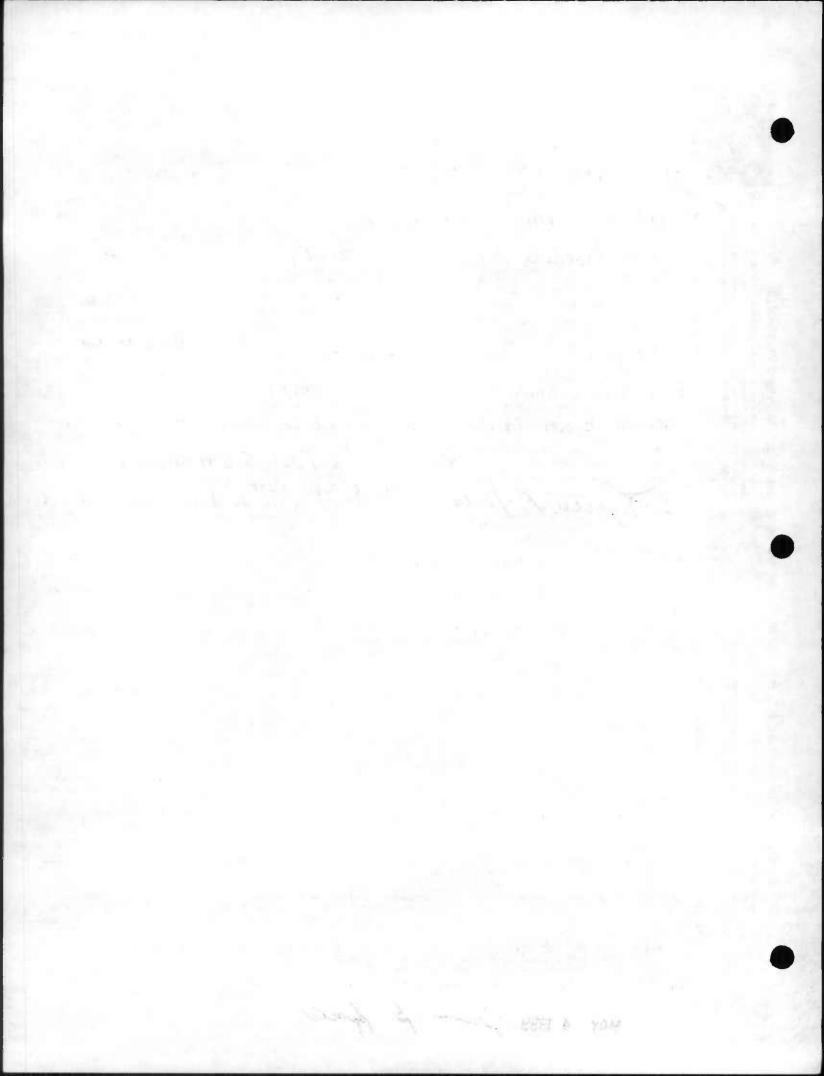
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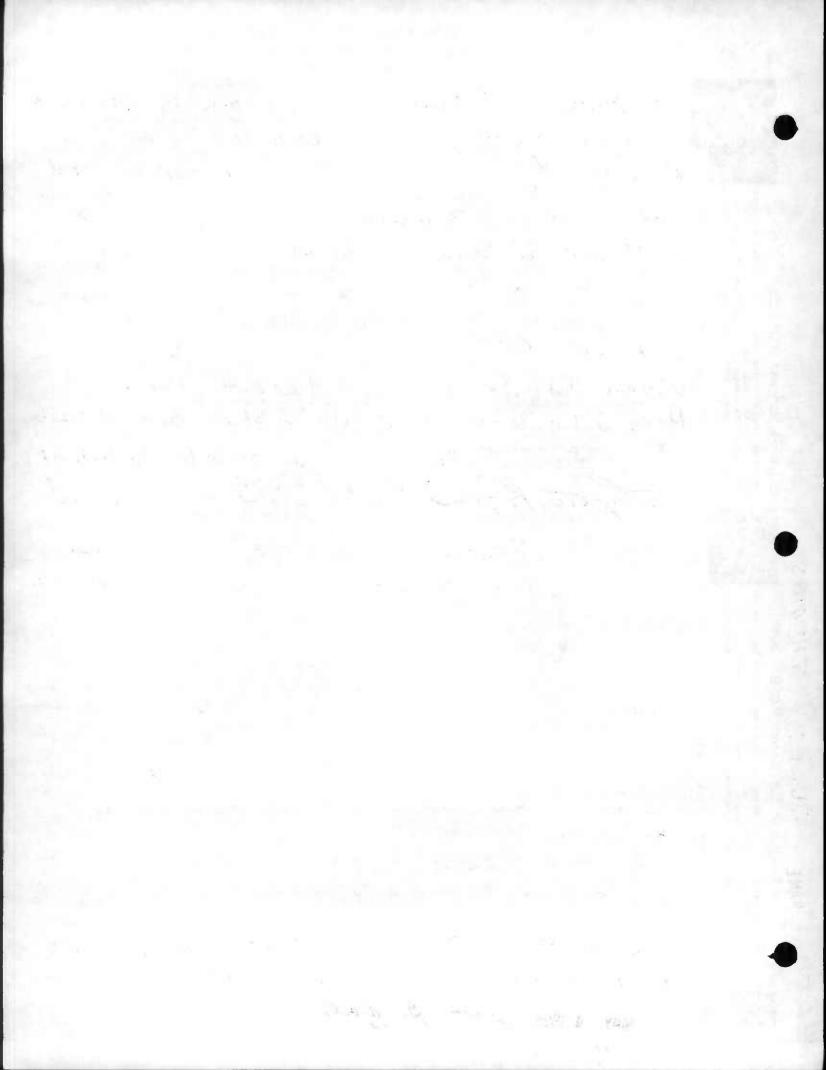
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 14434 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** KENNETH 1999 0612 A.M JOHNSON 30 APRIL /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner BALTIMORE BALTIMORE HOSPITAL If Under 24 Hrs. 8. If Under 1 Year Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 10/M 20 F Months Deys Hours Min Yrs. 214-62-6280 Director Usuel Residence of Decedent with the Meryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryler Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23s or 28s-f show says injury or other traumatic avent, the Medical Examiner must be nutriled at ence. Baltimore 1 Yes 2 □ No Md Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? N. U.S.A 21229 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black by 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Box Elementery/Secondery (0-12) College (1-4or 5+) Corragator NA 8th grade 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Anna 101 Augustine Johnson 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Belinda Brooks -N. Rosedale Balto, red zizza Street Friend 20e. Method of Disposition

1. Buriel 2 Cremation 3 Removel from State 20b. Piece of Disposition (Neme of emetery, crematory or other piece) Dete Location - City or Town, Stete 20c. Memorial Kanda (Istown, Md 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22, Name and Address of Fecility Barch F. H. West 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Da 140, md 21215 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) e PULMONARY EDEMA 6 hRS Examiner Due to (or es e consequence of): Physician/Medical Examiner hrs I NEUTROPENIA SEPSIS ettending physician and for use es the buriel-transit The law requires that the deeth certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 3 4rs MULTIPLE MYELOMA thet initiated events Due to (or as a consequence of): resulting in deeth) Last signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were eutopsy findings eveilable prior to been si 24a. Wes en eutopsy performed? Completed completion of cause of deeth? certificate has t lirector, page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 🔀 No or Attending Physician: 25. Wes case referred to medical examiner? director Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27 Manner of Deeth 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 1 X Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No deeth. Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide efter A 24 hour.
The Funeral Direction Hospital 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner stated. 29a. Certifier edical completely (Check only one) To the Pwithin 2 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Wonna tuersley m.D 10413 30th April 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 21215 2401 W. BELVEDERE AVENUE, BALTIMORE MARYLAND 31. Date filed (Month, Day, Year) State Registrar **DHMH 16 Rev 6/95**





Piease Type or Print in Biack indeiibie ink. Assure Aii Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** ERNestine Jones 1:00 Am may /Medical Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examine Baltmore
HUnder 24 Hrs. 8. Dar Medical NA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days Hours 220-22-5390 1□ M 20 F Director Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23s or 28s-f show traumatic avent, the Madical Examinar must be notified at Baltimore 1 Yes 2 No NA Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number , S 21215 · A U EllaMont 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Merital Status Black, White, etc. 72 hours after 1 Never Married 2 Merried 1 Yes 2 No If Yes, Give Year or Dates: Black 1 Yes 2 No Specify: À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pamilt. Pages 1 and 2 should be filed within? Department of Heelih and Mental Hygiana. Important: if hem 27 is marked other than "ready lijury or other traumatic avent, ma Mad police. Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) Home Home make er 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be lide 75 leanette Johnson 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BllaMonT tusband am 10nes 20b. Place of Disposition (Name of cometery, cremetory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State Forest 4 □ Donation 5 □ Other (Specify) naumson 21. Signature of Funeral Service Licensee 2/2/5 22 Name end Address of Fecility F. H. West Da Ne, Md gerenue nes Walast 300 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ail physician and s the buriai-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of) 188 signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contributa to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No à 24b. Were eutopsy findings eveilable prior to Completed 24a. Wes en eutopsy performed? peen s completion of cause of deeth? 1 ☐ Yes 2 ☐ No certificata 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospitel: 1 Dinpatient To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this funaral 27. Manne of Death 28a. Dete of Injury (Month, Dey Year) he Hospital or Attanding Ph in 24 hours after death. he Funeral Diractor: After th pletaly filled in by the funeral 28d. Describe how injury occurred Certification: 28b. Time of 28c. fnjury et Work? 5 Pending investigation Netural 1 Yes 2 No Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the F within 2 29b. Signeture and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) may 37-20 M.D

State Registrar

DHMH 16 Rev 6/95

Saltimore, Maryland 21215-0020

Division of Vital Records. P.O. Box 68760.

lerance 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

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32. Registrer's Signeture

Baltimore

Center

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nama (First, Middla, Last) AMonth AD 2. Data of Daath 3. Time of Death Yaar **Physician** JACILSON 1901 Ru BY CAZUTHERS PRIL 30 1999 /Medical 4b. City, Town, or Location of Deeth 4e Facility Nema (If not Institution, giva streat end number) 4c. County of Death Examiner GEN HOSPITAL HAZ FOLD FALLSTON FALLSTON If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 6. Sex 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Days 1 M 2 XF Yrs. 463 64 7861 Director Dec. 20,1906 Texas Usual Rasidence of Dacedent 10b. County 10c. City, Town or Location 10d. Insida City Limits Department of Health and Mental Hygiena. Important: or items 23s or 28s-f show important: If them 27 is merked other than "natural; or items 23s or 28s-f show any injury or other traumatic avent, the Medical Evantine must be notified at Monkton Maryland Harford 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Coda 3820 Marcus Court 21111 United States Funeral 12. Was Decedant Evar In U,S. Armed Forces? Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11 Marital Status Black, Whita, atc. 1 ☐ Yas 2 📉 No If Yas, Give 1 Navar Married 2 Married 1 ☐ Yas 2 X No Spacify: White Specify: à 3 Vidowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Education 12 Secretary 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be **Emma** Ruben S. Caruthers AKP 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Lynn J. Speedie / Daughter 3820 Marcus Court, Monkton, MD 21111 20b. Place of Disposition (Nama of cametery, cramatory or other piace) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2X Cramation 3 ☐ Ramoval from Stata 5/3/99 Green Mount Crematory 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore, MD 22. Nama and Addrass of Facility 21. Signature of Funeral Service Lic CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Ba
23a. Part1. Entir tha disaase, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. 21286 8717 Green Pastures Dr., Baltimore, MD Approximata tntarval Batween Onsat and Daath **Physician** /Medical Immadiate Cause (Final ASCUD disease or condition resulting in death) Examiner Dua to (or as a consaquanca of): Examiner physician and the burial-trensit Sequentially list conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Disease or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of) Physician/Medical Dua to (or as a consequence of) signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown à should I 24b. Wera autopsy findings evailable prior to 24a. Was an autopsy performed? Completed completion of cause of death? s cartificata has b director, paga 2 s 1 Yas 2 KNo 1 Yas 20 No director Be 25. Was casa rafarrad to medical examiner? 26. Place of Death (Chack only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Lo 1 Nas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this After this 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred Certification: 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending death. 1 ☐ Yas 2 ☐ No 2 Accidant invastigation within 24 hours after death To the Funeral Director: , completely filled in by the 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 3 Suicida 6 Could not be determined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida edicai 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the causa(s) and manner as stated 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. (Check only one) To the within 2 To the 29d. Data signad (Month, Dey, Year) 29b. Signature and title of certifier 29c. Licansa number

State Registrar

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30. Name and addrass of person who complated causa of death (Itam 23a) (Type, Print)

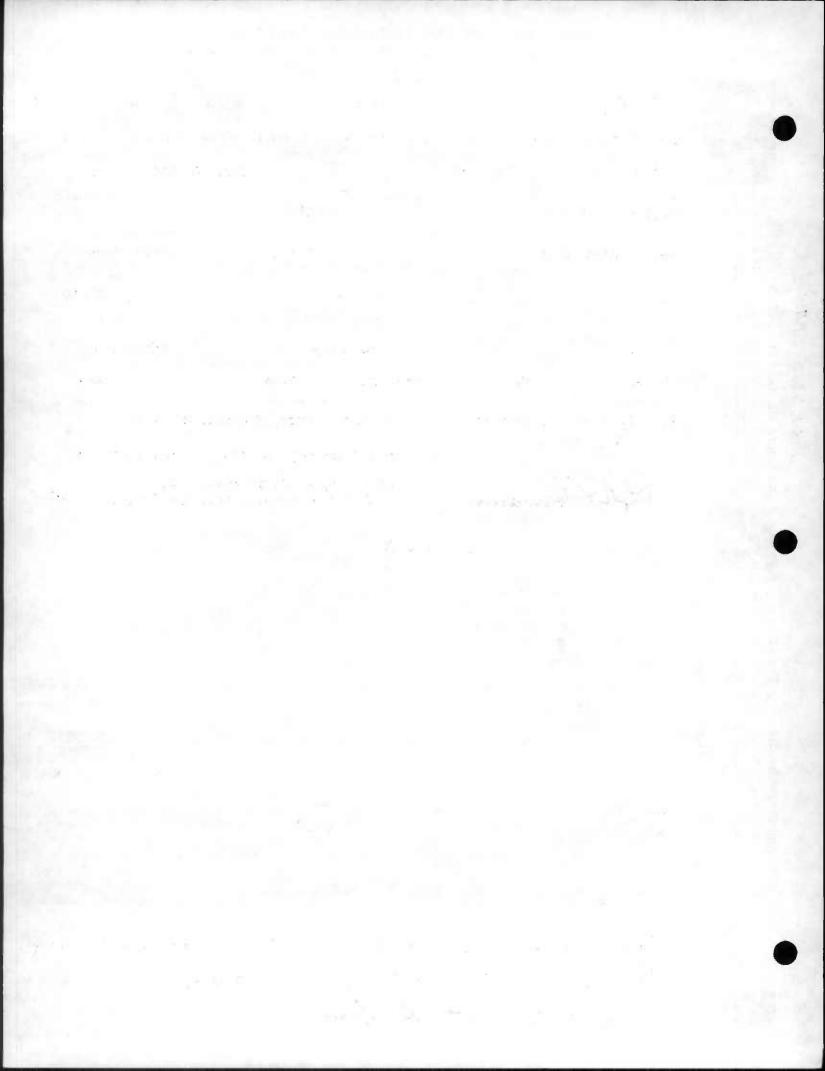
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 915 **Physician** LUCY JOHNSON 2 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltmore 1akylana General If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2X F Months Hours 98 9-23-00 Director 214-12-4807 N.C. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinat must be notified at 1 □XYes 2 □ No Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5505 MINNOKA AVE. 21215 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 11. Marital Status Biack, White, etc. 1 ☐ Yes 2X☐ No It Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: Specify: BLACK þ 3 ◯ Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) -12-NURSE -2-MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN FANNIE JOHNSON 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JAMES JEFFERSON(SON) 4645 POWHATEN LAKES RD. POWHATAN, VIRGINIA 23139 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 4 ☐ Donation 5 ☐ Other (Specify) ROSE LAWN MEMORY GARDENS 5-5-99 GLEN ALLEN, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. DecIn CFSP 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence ot) Examine physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence ot) Obstructive Pulmonary Disease Physician/Medicai Due to (or as a consequence of) 98 eumonia USB 0 signed by tha e Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Obstruction 2 No 1 Tyes 1 ☐ Yes 2 ☐ No 25. Was case reterred to medicei examiner? Be 26. Piace of Death (Check only one) Hospitai: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funaral 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 ☐ Accident tha 6 Could not be determined 28t. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner es stated. complately 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date tiled (Month, Dar, Year) 1999

30. Name and address of person who completed cause of geath-(Item 23a) (Type, Print)

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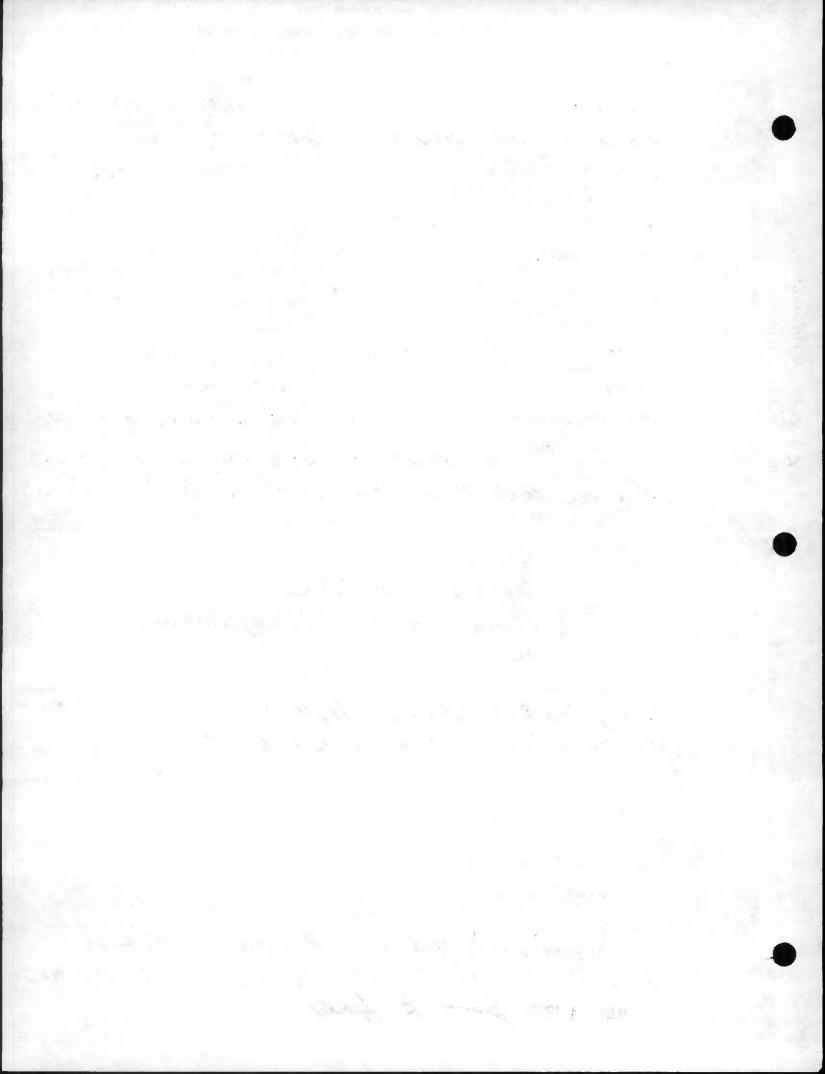
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Division of Vital Records, P.O. Box 68760,

Baltimore,

Haalth 8

Johnson



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** 13, April 1999 10:30PM G. R. F. Key /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner WOODSIDW NURSING HOME Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Months Days Hours 15 M 2□ F Yrs. Director 252-12-8156 103 Jan 10, 1896 Washington, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County N☐ Yes 2☐ No DC Washington Directo 10e. Street and Number 10f. Zip Coda 10g Citizen of What Country? permit. Peges 1 end 2 should be filed within 72 hours after death with I Depertment of Haalth end Mental Hygiena. Important: If Item 27 is marked other than "naturel", or items 23s or 3 any highry or other traumetic event, the Modical Examiner must be nonce. 20018 2360 13th Place N.E. USA Funeral 12. Was Decedent Evar in U.S. Armed Forces? 1 ½Yes 2 □ No If Yes, Give Year or Datas: unknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yes ŽIXNo Specify: p 3 ☐ Widowed 4 ☐ Divorced Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Collaga (1-4or 5+) Elamantary/Secondary (0-12) 4+ Reference Librarian DC Gov't. 18. Mother's Name (First, Middle, Maidan Sumame) 17. Father's Name (First, Middle, Last) Joseph Henry Key Harriet White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 1650 Harvard St. NW #704 Washington, D.C. 20009 Marcia Greenlee/Friend 20b. Place of Disposition (Name of cametery, crematory or other placa) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-4-99 Clinton, Md. Christ Episcopal Church 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home of Maryland witon 4308 Suitland Rd. Suitland, MD. 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** erebrovascular accident /Medical Immediate Cause (Final disease or condition rasulting in daath) Examiner Examine Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disaasa or injury Due to (or as a consequenca of): Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown USIOU þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed unsonom completion of cause of death? 2 No 1 Yes 1 ☐ Yas 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 ☐ Residanca 6 ☐ Other (Specify) Certification: To 1 Yas 2 NA 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datermined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Certifie edicai (Check only one) 29b. Signature and you of ned (Month, Day, Year) 30. Name and address a person who compared cause of death (Item 23a) (Type, Print) 8700 Georgia Ave. Povar Silver Spring, Md. 20910

Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signatura

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Division of Vital Records, P.O. Box 68760,

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Please Type or Print In Black Indelible ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2 Date of Death Month Dey **Physician** 10:50 a.m. 30, 1999 Timothy Franklin Kelly April /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) **Examiner** Gilchrist Center Baltimore N/A If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys XXM 2□ F 62 Yrs. Director 213-34-3831 Dec. 13, 1936 Maryland Usuel Residence of Decedent the Merylend 10e. Stete 10h County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Baltimore Baltimore Maryland 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number with 1 21224 618 48th Street United States deeth \ Funerai 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11 Maritel Status of filed within 72 hours efter all Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify:White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16h Kind of Rusiness/Industry Elementery/Secondary (0-12) College (1-4or 5+) Civilian Balto, Police Dept. Law Enforcement 12 years permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Important: if item 27 is marked other any Injury or other traumatic event DICE. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Peter James Kelly Ruth Manley 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 618 48th Street Baltimore, Maryland 21224 Joan Kelly (Wife) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 5/3/99 Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Funera Servica Licensee 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 260 7922 Wise Avenue Dundalk, Maryland 21222 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feiture. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical CAncer Examiner Due to (or es a consequence of): Examiner certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest physiclan end s the buriel-tren Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or as a consequence of): 98 ettending for use es The law requires that the death by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy peed performed? hes e 2 certificate he 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 05/016 this 27. Menner of Deeth 28c. Injury at Work? Certification: 28d. Describe how injury occurred 28b. Time of After 1 Neturel 2 Accident 5 Pending efter death.

Director: Aft
d in by the fur 1 □ Yes 2 □ No Investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours or To the Funeral Completely filled edicai tax Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) 29a. Certifier end menner steted. 29d. Dete signed (Month, Dey, Year) 29b. Signature and the of partifie 29c. License number m) Balto, md 21204 completed cause deeth (Item 23e) (Type, Print) N. Charles St.

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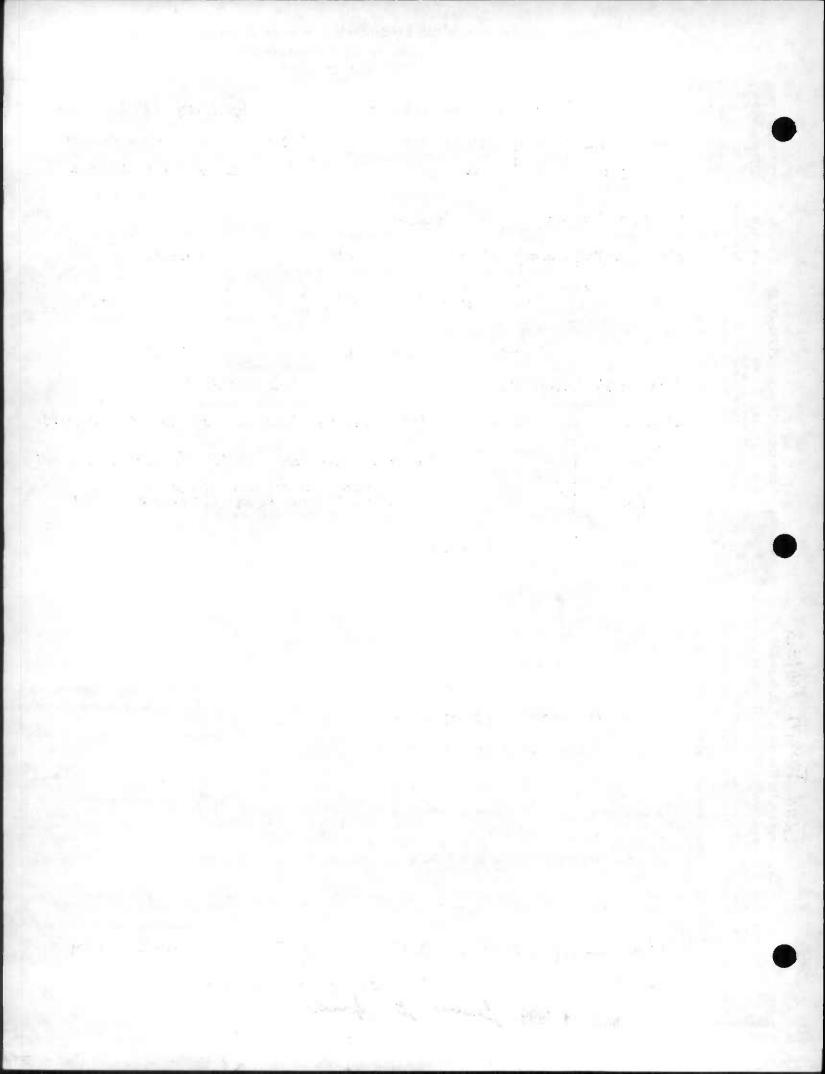
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** April JOJEP 4 KOHLES NHOL 0918 29 /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner FALLSTON GENERAL HOSPITAL FACUSTON

If Undar 24 Hrs. 8. Data of Birth
Hours Min. Dec. 30, HANFOND 7. Aga (In yrs. last birthday) If Under 1 Year 5. Social Security Number 9. Birthpleca (Steta or Foreign **Funeral** Year) 18 10 M 20 F Months Deys Maryland 80 Yrs 219-16-2582 **Director** Usuel Residence of Decedent with the Maryland r 28a-f show 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 X No Maryland Harford Abingdon Directo 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If Item 27 is merked other than "natural", or itsma 23a or set in Injury or other traumatic event, the Medical Examiner must be an once. 3506 Back Point Road, Unit 3C 21009 U.S.A. Funeral 12. Was Decedant Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian Bleck, White, etc. 1 X Yes 2 □ No If Yes, Give Yeer or Datas: 1941-45 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ White 3 Wildowed 4 Divorced Completed 16e. Decadent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Accountant I.R.S. years 18. Mother's Nema (First, Middle, Maiden Surname) 17. Fathar's Neme (First, Middle, Last) John Joseph Kohles. Sr. Pauline Wilhelm 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Margaret A. Kohles (Wife) 3506 Back Point Road, Unit 3C, Abingdon, MD.21009 20e. Method of Disposition 20b. Placa of Disposition (Nema of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stata 1 X Buriel 2 Cremation 3 Removal from State 4 Posation 5 Other (Specify) Most Holy Redeemer Cem. 5/3/99 Baltimore, Maryland of Funeral Service Licensee 22. Neme end Address of Fecility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21 21014 Me 23e. Part1. Enter the disease shock, or heart failure. or complications that causad tha daeth. Do not enter the mode of dying, such as cardiac or respiretory errest, ist only one ceuse on each line. Approximate Intervel Between Onset and Death **Physician** ASWD. Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of): Physician/Medical Examiner attending physician and for use as the bunal-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequenca of) John Joseph Kohles that initiated events resulting in deeth) Last Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 | Yes 2 | No 3 | Probably 4 | Onknown ACTIVE GE BLEED þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performad? Completed ATMAL FIBRILLATON To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificata has t completaly filled in by the funeral director, paga 2 s 1 Yes 2 No 1 Yes 20 No Be 25. Was case referred to medical exempler? 26. Piece of Death (Check only one) 1 Yas 2 No To Hospital: 1 ☐ Inpatient 2 □ EFVOutpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Numbar or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, straet, fectory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier edicai 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number 4-29-1999 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Ganesh Prabhu M.D., 218 Fulford Avenue Bel Air, MD. 21014 31. Dete filed (Mohth; Day, Year) 32. Registrar's Signature State Registra



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** witta 1999 6:40 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth Fecility Neme (If not institution, give street end number) Examiner +OSDI+A Dalt tactimore more ove Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Yeer) **Funeral** Days 1XM 2□ F 218-32-2056 MD Director 92 MAY 11, 1906 Usual Residence of Decedent the Meryland 10c. City. Town or Location 10d. Inside City Limits 10a Stele 10h County r than "naturel", or items 23a or 28a-f ehor 1 Yes 2 No Director MD N/A BALTIMORE 10e. Street end Numbe 10f. Zip Code 10g. Citizen of Whet Country? with 6316 GREENSPRING AVENUE #305 21209 U.S.A. Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. filed within 72 hours efter 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) OWNER LATTIN SALES COMPANY 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked oth any linjury or other treumatic event page. LATTIN HARRY SARAH BEROSOFSKY 19a. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) LOTTIE LATTIN / WIFE 6316 GREENSPRING AVE. #305 - BALTIMORE, MD 21209 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremetion 3 ☐ Removal from State BETH TFILOH CEMETERY 5/3/99 WOODLAWN, MD 4 Donetion 5 Other (Specify) 22. Name end Address of Fecility 21. Signeture of Funeral Service Licenseen SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, 21208 23a. Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner OK certificate be executed sicien end buriel-tren Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury Box 68760, attending physicien for use es the burie (Jas Physician/Medical Due to (or es e consequence of): resulting in deeth) Lest 8 lew requires that the deeth signed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Mrthown Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy Completed peen performed' hes The 1 Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospitel: 1 impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) L_o 1 Yes 2 No this 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation fnjun 1 Naturel efter death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and placa, end due to the ceuse(s) edical 29a. Certifier and menner stated. 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signeture end title of certifier D005441 person who completed cause of deeth (Item 23a) (Type, Print) Belveden 31. Dete filed (Month, Day, Year) 40.1. West 32. Registre State MAY Registrar

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sets from the manual colonide of the and - where I will a say of

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Daeth 3. Time of Deeth Month Day Yaar **Physician** MAY 1:30PM 1999 ELMER LEE MEYER JR. /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Nama (If not institution, give street end numbar) Examiner 1406 If Under 24 Hrs. 8. Data of Birth
Hours Min. (Month, Dey, Year) TENBURY ROAD BALTIMORE 5. Social Sacurity Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 6 Sax **Funeral** 18M 20F Months Deys Yrs. 216-16-1410 Director MD Usuel Residence of Decedent with the Marylend 10a Steta 10h County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 PNo Director MD BALTIMORE LUTHERVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after deeth with Hygiene. ther than "naturel", or frems 23a or in the Modical Examiner must be n U.S.A ROAD 21093 Funeral 1406 TENBURY Was Dacedent of Hispenic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, 12. Was Dacedent Ever in U.S. 11. Maritel Status Armed Forces? Black, Whita, etc. 1 ☐ Nevar Married 2 ☐ Married 1 Yes 2 No Specify: þ 3 ☐ Widowad 4 ☑ Divorced Yaer or Detes: ARMY WHITE Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TRAFFIC ENGINEER BALTIMORE COUNTY 12 other 7 is marked other 18. Mother's Neme (First, Middla, Maidan Sumama) 17. Fether's Neme (First, Middle, Last) Be 1 and 2 should be Health and Mental E. WALTERS FLMER LEE MEYER, OTILIA 19b. Maiting Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Coda) 19a, Informent's Name/Relationship (Type, Print) Itam 27 i LUTHERVILLE, MD. 21093 1406 TENBURY RD. GEORGE I. MEYER 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition Pages 1 nent of H nnt: If Ita MAY 6, 1 Burial 2 Cremation 3 Removal from State Department of Important: If any Injury or price. 4 ☐ Donetion 5 ☐ Othar (Spacify) LOUDEN PARK CEM, 1999 CATONS VILLE, MD 22. Name end Address of Facility EVANS CHAPEL OF CHIMES 21. Signature of Funeral Spryice Cittinges 21093 2325 YORK RD. TIMONIUM, MD. 23a. Pert1. Enter the disease, or complication that caused the deeth. Do not enter tha moda of dying, such es cardiec or respiratory errest, shock, or haart failura. List only ona cellular neech line. Approximata Intervel Between Onset end Deeth Physician months Lung Cancer /Medical tmmediata Causa (Final diseese or condition resulting in deeth) Examiner Dua to (or es a consaquence of): Examiner physicien end s the buriel-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Last Due to (or es e consequence of): Physician/Medical Dua to (or es a consequenca of): 80 for use es signed by the a 23b. Did tobacco use contribute to the cause of death? Part tt. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Yes 2 No 3 Probably 4 Unknown P 24b. Ware eutopsy findings avellable prior to completion of ceuse of deeth? been si 24e. Was en eutopsy Completed certificate has lirector, page 2 s The 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No Division of Vital director. Attending Physician: 25. Wes cesa rafarrad to medicel Be 26. Piece of Deeth (Check only one) exeminer? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) P 1 Yas 2 No this After thi funeral 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Naturel death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / 6 Could not be determined 3 Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, Steta) 28e. Piece of Injury - At home, farm, street, factory, offica building, atc. (Specify) 4 Homicide ò 24 hours aft Funeral Di vietaty filled In 12 Certifying Physician: To tha best of my knowledga, daeth occurred et the time, deta end place, and dua to tha ceuse(s) and mennar as stated. 29a. Certifier edical (Check only one) 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred et tha tima, data and place, and due to the ceuse(s) and mannar stated. Within 2
To the I
Complete 29d. Dete signed (Month. Dev. Year) 29b. Signeture end title of certifier 29c. Licanse number Mark Cams 134521 MAY 30. Name end eddress of person who completed causa of daeth (Itam 23a) (Type, Print) HUNT VALLEY, MD. 9 SCHILLINGED STE, 1 DR. MARK LAMOS 31. Data filed (Month, Day, Year) 32. Registrer's Signeture State

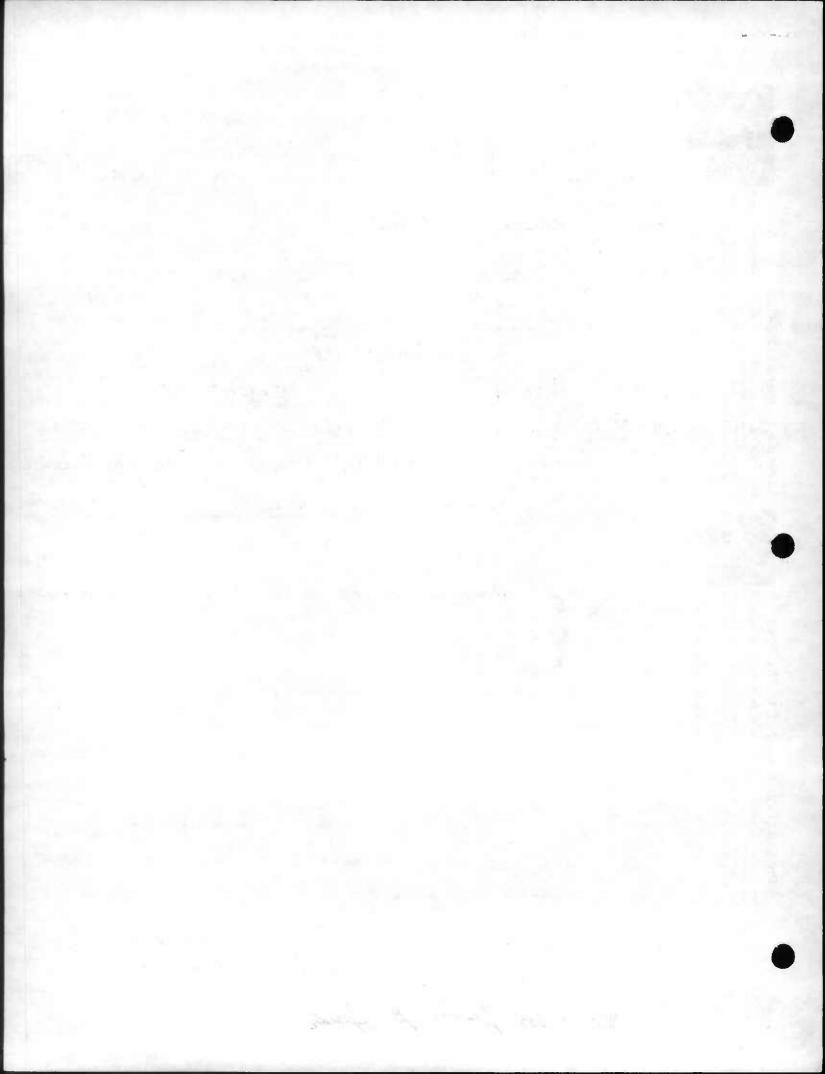
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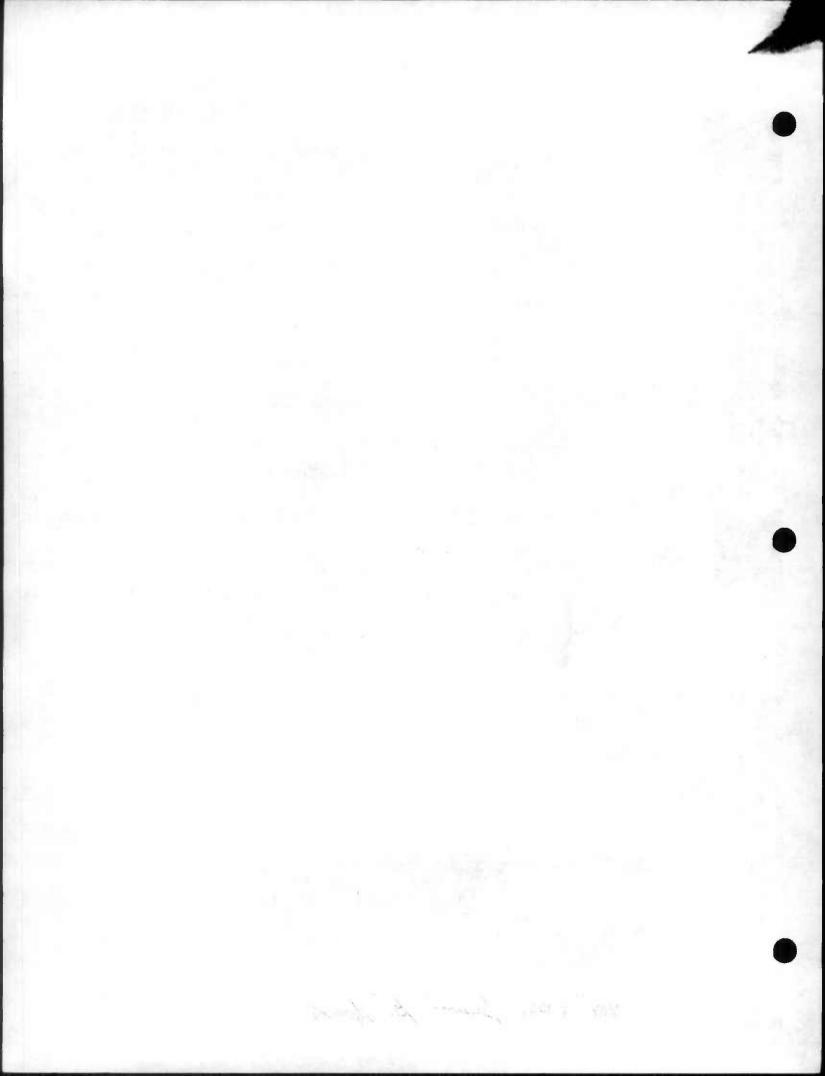
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle Last) 2. Date of Death Day MILLER **Physician** MARIE 1:00 pm APri 28 1939 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not Institution, give street end number) Examiner Samaritan M Under 1 Year | M Under 24 Hrs. | 8. Dat Mospital 000 6. Sex 1□ M 2XF 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min 220-22-2036 Usual Residence of Decedent Yrs. Director with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examiner mant be notilled at Baltimore 1 ☐ Yes 2 No Directo Mo 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 2613 Rd 21234 Funerai death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours efter Department of Heelift and Mental Hygiene. Important: If item 27 is merked other than "natural", or ite any Injury or other traumatic event, in a waite factor. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cottege (1-4or 5+) Elementary/Secondary (0-12) nomemaker nome 18. Mother's Name (First, Middle, Malden Surname) 17. Fether's Name (First, Middle, Last) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, informant's Name/Relationship (Type, Print) Mari 21044 Ma Columbia. 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State May Valley Mem Gard 1999 22. Name and Address of Facility Evans 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, sudhas cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Hd 2123C Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) neumonia two days Examiner Due to (or as a consequence of): Physician/Medical Examiner 18 months Metastatic Recta Lonler ettending physician end for use es the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were eutopsy findings available prior to completion of ceuse of death? Completed 24a. Wes en eutopsy performed? been s has certificate 1 ☐ Yes 2 ☑ No or Attending Physician: director, 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) Certification: 1 Natural 5 Pending Investigation 1 Yes 2 🗆 No 2 ☐ Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 24 hours a Hospital edicai 29a. Certifier 1💢 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) J. hard ousset MD 1,0584 Apr. L, 28, 1999 Youssef, ND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 loch Raven Blvd., Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State books Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** 12abeth Anna 6:00AM DRi /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Emerald Rd Baltimore 5. Social Security Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar 6. Sax 8. Data of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F 860 Months Hours 212-10-5623 Usual Residence of Decedent -10 Yrs. Director Eeb with the Meryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director VHMOR 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code ò 2902 items 23a 14. Race - American Indian, Black, White, etc. filed within 72 hours after deeth 12. Was Decedent Evar in U,S.
Armed Forcas?

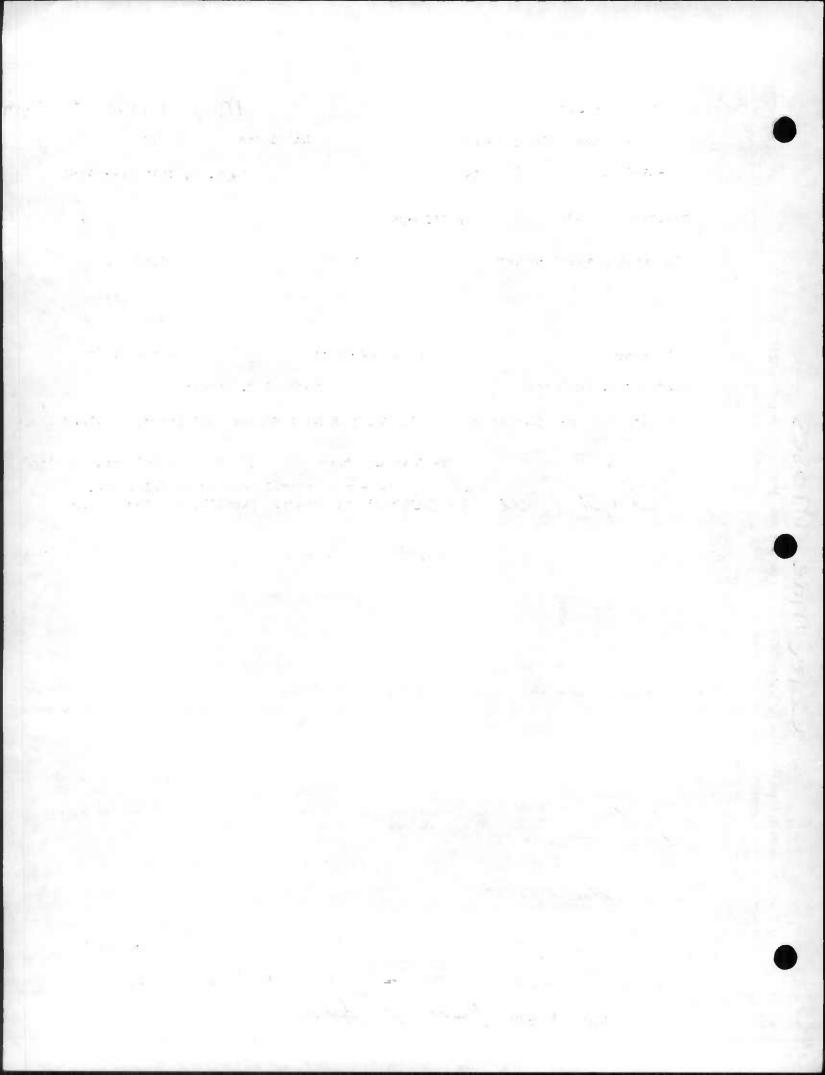
1 Yes 2 No
If Yas, Giva
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White Maryland 21215-0020 ò 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced "naturel". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementery/Secondery (0-12) TailOR COOPK 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Heelth and Mental Hy ant; if Item 27 is marked oth Dilamena 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barrwall ackville Md 21234 oe other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State May 1 Burial 2 Cramation 3 Removal from State 7 Department of important: If any injury or section 4 ☐ Donation 5 ☐ Other (Specify) 199 Of 21. Signature of Fameral Service Licenses 22. Neme and Address of Facility uneral Chapel vans Rtord Baltimore 8800 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Death Physician fmmediate Causa (Final disease or condition resulting in death) /Medical Malnutrition days **Examiner** Due to (or as a consequence ot): Physician/Medical Examiner Alzhemier tdvanced The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown steoporosis þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate hes 2 No 1 ☐ Yas 2 ☐ No 1 Yes or Attending Physicien: 25. Was casa reterred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be To the Hospital or Attending Physici within 24 hours after death.

To the Funerel Director: After this ce completely filled in by the funeral dire Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Netural 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. (Check only one) 29b. Signature and Jille 29c. License number 29d. Date signed (Month, Day, Year) DO051926 who completed cause of death (Item 23a) (Type, Print) 30. Nama and address of person TOWSON, Md 21204 6569 32. Registrar's Signature State 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 4 6 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 3. Time of Death

Physician /Medical Examiner	1. Decedent's Name (First, Middle,	Last)												
/Medical	Cora Mao Mocos	1. Decedent's Name (First, Middle, Last)							Date of Dea Month	Day, Year				
	Cora Mae Moses										9:450			
	4a Facility Name (If not institution, give street and number) 4b. City, Town,									4c. County	of Death	9		
								timore	9	N/A				
al or	5. Social Security Number 220-09-5445	7. Sex 1 □ M 2√2 F	Age (In yrs. I	last birthday) Yrs.	If Under Months	r 1 Year Days		Min.	B. Date of Birth (Month, Day Sept. 8	, Year)		ace (State or Foreign ry) land		
	Usual Residence of Decedent													
	10a. State 10b. County			, Town or Lo	cation						10	Od. Inside City Limits		
cto	Maryland N/A		Balt	imore								1□ Yes 2□ No		
Oir.	10e. Street and Number				10f. Zig	Code				10g. Citizen of \	What Count	try?		
by Funeral Director	312 South Newkir	k Street			21	224		United States						
by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Give	es? LXNo		Vas Dece Yes, spe				ity Yes or No- icen, etc.)	14. Rad Blad	e - America ck, White, e	nn Indian, etc.		
8	15. Decedent's	Year or Date	15.	16a. Deced	ent'e Heu	al Occu	nation		1					
Completed	(Specify only highest	grade completed)		(Give	kind of wo	ork done	during mos	t of working	7	TOD. TAING OF D	3311103371110	ustry		
Ē	Elementary/Secondary (0-12) 10 years	College (1-4	or 5+)	Lever						Manufa	cturi	na		
Ö	17. Father's Name (First, Middle, L.	est)		20101				er's Name	First, Middle,	dle, Maiden Sumame)				
o Be	Benjamin F. Parl						Racha	el E	Turpi					
F	19a. Informant's Name/Relationshi			19h Mailin	o Address	e (Strag					State Zin	Code		
	Perneita Zeiters	(Daughte	r)		-									
	20a. Method of Disposition	Daugiree						20166	Date					
	1 Burial 2 □ Cremation	Removal from Sta	ate	lace of Dispos emetery, cren	natory or o	other pla	ice)	1	Duto					
any mjury or ourse usumauc event, its montest once. To Be Completed	4 Donation 5 □ Other (Spe	cify)	Oak	Lawn	Ceme	ter	У	5,	/5/99	Balti	more,	Maryland		
completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit a p p p Redical Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):										3 /2 2 2 4 4 1 5			
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ysic	Pert II. Other significant condition	s contributing to deat	h but not resu	iting In the ur	derlying	cause gi	ven in Pert	l.	23b. Did t	obacco use co	use contribute to the cause of death?			
モ									1 Yes 2 No 3 Probably 4 Ur					
Be Completed by Physician/										an autopsy med?	con	re autopsy findings Illable prior to Inpletion of cause deeth?		
dmo										es 26 No				
g o									101		11	Yes 2 No		
Be Be	25. Was case referred to medical examiner?	Hospital:				. 0	her		eath (Check only one)					
completely filled in by the funeral director, page Medical Certification: To Be Com	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dete of I	28a. Dete of Injury (Month, Day Year) 28b.			me of 28c. Injury at Work? M 1 Yes 2 No		28	g Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred) Witie			
Certifica	3 Suicide 6 Could no determine	Ad 288, Place of	Injury - At ho , etc. (Specify	ry - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Num City or Town, State)					i Route Number,					
edical		Phyalclan: To the be aminer: On the basis and manner	s of examinat											
N N	29b. Signature and title of certifier				29		se number			29d. Date signe	d (Monthy I	Day, Year)		
	by the	Jm				D	4085	4		S	12/2	٦		
	30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)							Bal	trere	2120	Z			



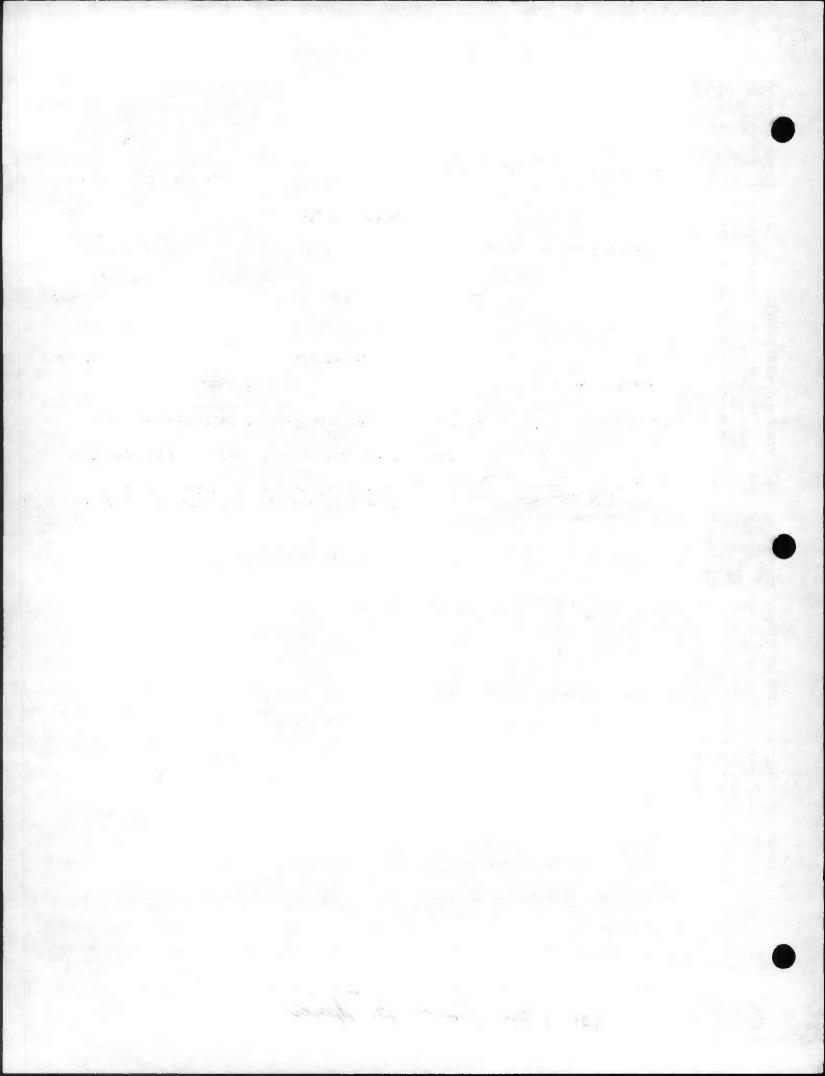
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State of Maryland / Department of Health and Mental Hygiene 9 | Li Li T

					Certificate c	f Death	F	Reg. No.					
ysician	1. Decedent's Name (First, I	Aiddle, Last)	11 -			2. Date of Dea	Day Year 25						
n al	Ma	ry M	iller				April	29 1	999	122 pm			
niner	4a Fecility Neme (If not insti	tution, give stre	eet end number)				Location of Death						
	Sinai H		Bulhr		N/								
al r	5. Social Security Number 447–30–4837		7. Age	irthday) If Under 1 Ye Yrs. Months Da		. (Month, Da	v, Year) 25, 1931	Count	ace (State or Foreign lry) PA				
	Usual Residence of Deceder 10a. State 10b. Co			10c. City, To	wn or Location				10	Od. Inside City Limits			
o	MD N,	/A			Baltimore	City				tores 2 □ No			
Funeral Director	10e. Street and Number 1820 Spence	Street,	# 302		10f. Zip Cod 2	1230		10g. Citizen of What Country? United States					
by	11. Maritel Status 1 Never Married 2	. Was Decedent E Armed Forces? 1 Yes 3 No If Yes, Give Yeer or Detes:		13. Wes Decedent of Yes, specify C		Specify Yes or No- rto Rican, etc.)	14. Reco	e - America k, White, e					
Completed	15. Dec	15. Decadent's Education 16a. De (Specify only highest grade completed) (G					orkina	16b. Kind of Bu	siness/Ind	ustry			
up id	Elementary/Secondary (0-		College (1-4or 5+	-)	(Give kind of work do life. DO NOT use re	ired)							
Ö	8		0		Home	naker	(Final AC) H-			wn Home			
marked other the	17. Father's Name (First, Mid George Sci	nirf					ame (First, Middle, C. Thamm	Maiden Sumam	10)				
L			0.1.0	- 4-				. Ch T	Otata 7'a	0-4-1			
	19e. Informant's Name/Rela Catherine M				b. Mailing Address (Str. 1521 Clark)				212:				
	20a. Method of Disposition	· Heage	5 / Daug		of Disposition (Name of		Date	20c. Location -					
	1 ☐ Burial 2 Crema		novel from State	cemet	ery, crematory or other Mount Cem	place)		Baltin	•				
	4 Donation 5 Oth												
Duce.	21. Signature of the all Sel	Signature of the ral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc.											
ian cal ner	Immediate Cause (Final disease or condition resulting in death)	a			I'M Infar a consequence of): 1'S	chin				3 mon Uns			
sician end bunal-trensit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying											
m	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			20 10 (0, 20	a consequenca of):								
ledical Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c			a consequence of):								
an/Medical Examiner	I that initiated events	d											
sician/Medical Ex	I that initiated events	L d	D	ue to (or as a	consequence of):	given in Part I.	23b. Did	lobacco use co	ntribute to	the cause of death?			
by Physician/Medical Ex	resulting in death) Last	L d	D	ue to (or as a	consequence of):	given in Part I.		lobacco use co Yas 2□ No		3/			
by Physician/	resulting in death) Last	L d	D	ue to (or as a	consequence of):	given in Part I.	1 🗆		3 Prob	3/			
by Physician/	resulting in death) Last	L d	D	ue to (or as a	consequence of):	given in Part I.	1 🗆	Yas 2□ No en eutopsy rmed?	3 Prob	pably 4 Unknown are autopsy findings bilable prior to mpletion of cause			
Completed by Physician/	resulting in death) Last Pert II. Other significant con 25. Was case referred to me	d	D	ue to (or as a	consequence of):		1 □ 24e. Was perfo	en eutopsy rmed?	3 Prob	ere autopsy findings eilable prior to mpletion of cause death?			
Be Completed by Physician/	resulting in death) Last Pert II. Other significant cor	d iditione contril	D	ue to (or as a	consequence of):	26. Place of Di	1 □ 24e. Was perfo	en eutopsy rmed? Yes 2 No	3 Prob	ere autopsy findings eilable prior to mpletion of cause death?			
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edical Certification: To Be Completed by Physician/	25. Was case referred to me examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 P. 2 Accident 3 Suicide 6 C. 4 Homicide Cer	d addical Hos anding vestigation outld not be elemined	spital: Impatien 28a. Date of tnjury (Month, Day 28e. Ptace of Injur building, etc.	tue to (or as a not resulting to	Outpatient 3 DOA Injury M	26. Place of Do Other: 4 \sum Nursing njury et Nork? Yes 2 \sum No ce	24e. Was performed to the seath (Check only of the seath (Check only only only only only only only only	en eutopsymed? Yes 2 No	3 Prob 24b. We ave cor of (1 Cer (Specif) red	pably 4 Unknown are autopsy findings aliable prior to mpletion of cause death? Yes 2 No When the Number, aliable death.			
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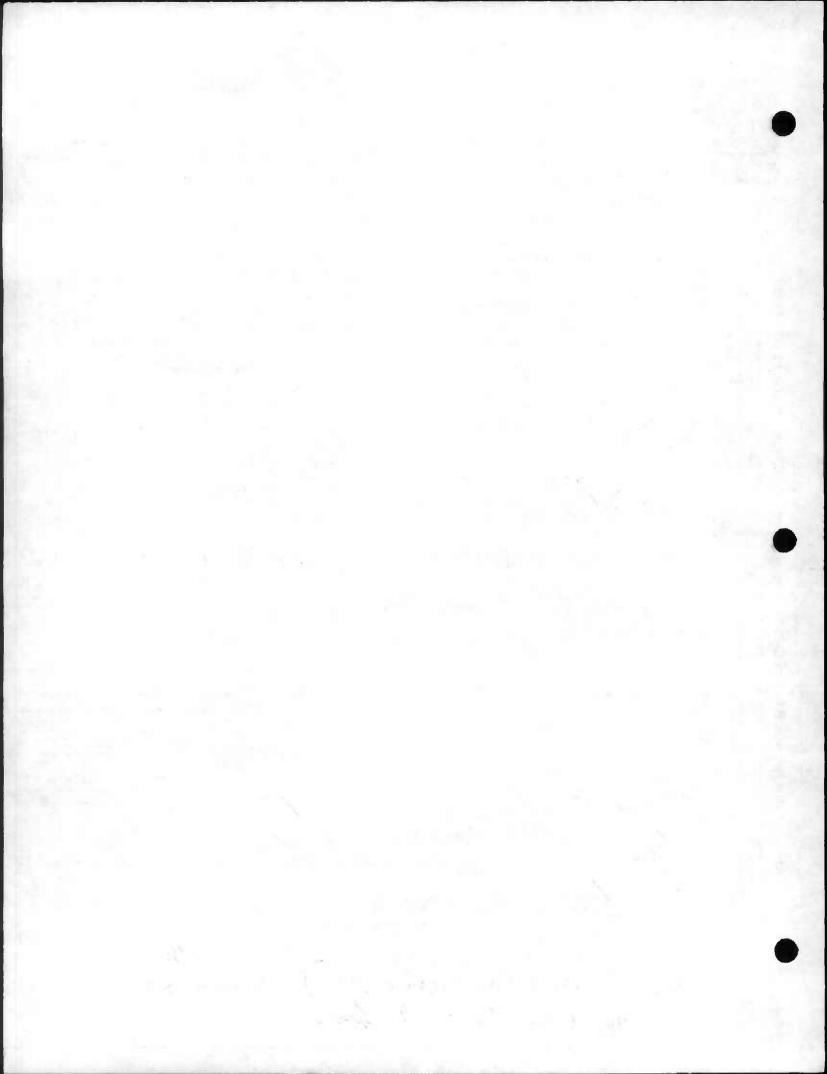
Registrar

MAY 4 1999 Direct B. Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () ()

Physician	1. Deced	lent's Name (First, Mi	iddle, Last)						2. Dete of Death			3. Time of Death	_			
Medical	LeR	Moreland, Sr.			Sr.			May			4:15 pm	l				
/Medical Examiner		Facility Name (If not institution, give street a				100	No.	4b. City, Town, or I	ocation of Death	4c. County	of Death					
Funeral Director			-	verna Park				Severna 1				rundel				
	214	Security Number 1-05-0172 esidence of Decedent		M offic	Age (In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month Day			9. Birthplace (Stete or Foreign Country) Maryland				
dand in	10a. Stat				10c. City	, Town or Loc	cation				100	10d. Inside City Limits				
Many	MI	Anne	Arun	del	Ed	gewate	r					1 ☐ Yes 2√ No	,			
vith the Me t or 28s-f a be notified Director	10e. Stre	et and Number					10f. Zip Code		10	g. Citizen of V	Vhat Countr	y?				
23a rail	26	47 Solomo					2103			USA						
within 72 hours after death with the Maryland ens. then 'raturel', or items 23s or 28s-f show has leadest Earning mant be notified at empleted by Funeral Director	зКіл	al Status Never Married 2 ☐ N Widowed 4 ☐ Divord	Married	2. Wes Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? X No		Vas Decedent of Nas, specify Cub ☐ Yes 2 No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Blec	k, White, et	c.				
72 ho		15. Deced	dent's Educ			16a. Deced	ent's Usual Occup	pation during most of wor	kina	16b. Kind of Bu	siness/Indu	ican Indien, o, etc. ite industry ern al Station ip Code) Town, Stete MD				
ed within 72 ho ygiene. or then "naturn ft, fre wedged.	Elemen	ntary/Secondary (0-12		College (1-4d	or 5+)	Weldi:	OO NOT use retire	d)								
should be filed within and Mental Hygiena. marked other than umatic avent, the Marrian To Be Comp	17. Fathe	1 Z or's Name (First, Midd	fle, Last)			weidi	ng	18. Mother's Nan	ne (First, Middle, N			pern ntal Station a, Zip Code) or Town, Stete 5, MD 21401 Approximate Interval Between				
should be filed nd Mental Hygi marked other imatic avent, To Be Cc	Lo	Louis Hamilton						Lillie	e Neumaye	r						
2 should be and M la marraumer		19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or F									y or Town, Stete, Zip Code) 21035 Location - City or Town, Stete nnapolis, MD A. Lis, MD 21401 Approximate Interval Between					
of Heath a Mam 27 is nother tra-	Ba	rbara Mil	ler (Daughte				Davidson	ville, MD	21035						
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permit. Pag Department Important: i any injury o	21. Signa	21. Signature of European Survice Licensee 22. Name end Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401														
icate be executed physician and s the burlal-transit edical Examiner	unat initia	ially list conditions, ading to immediate inter Underlying Disease or injury ited events in death) Last	{ b.			r es e consequ				•						
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as that the death certification of the death of the detached for use as by Physician/Me	Part II. Ot	ther algnificant cond		ributing to death	a but not resu			ven in Pert I.		e 22 No	3 Probe					
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State Registrar

MAY 04 1999

Jennis

31. Dete filed (Month, Day, Year)

32. Registrar's Signature

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30. Name end eddress of person who complated causa of death (Item 23a) (Type, Print)

B. Spark

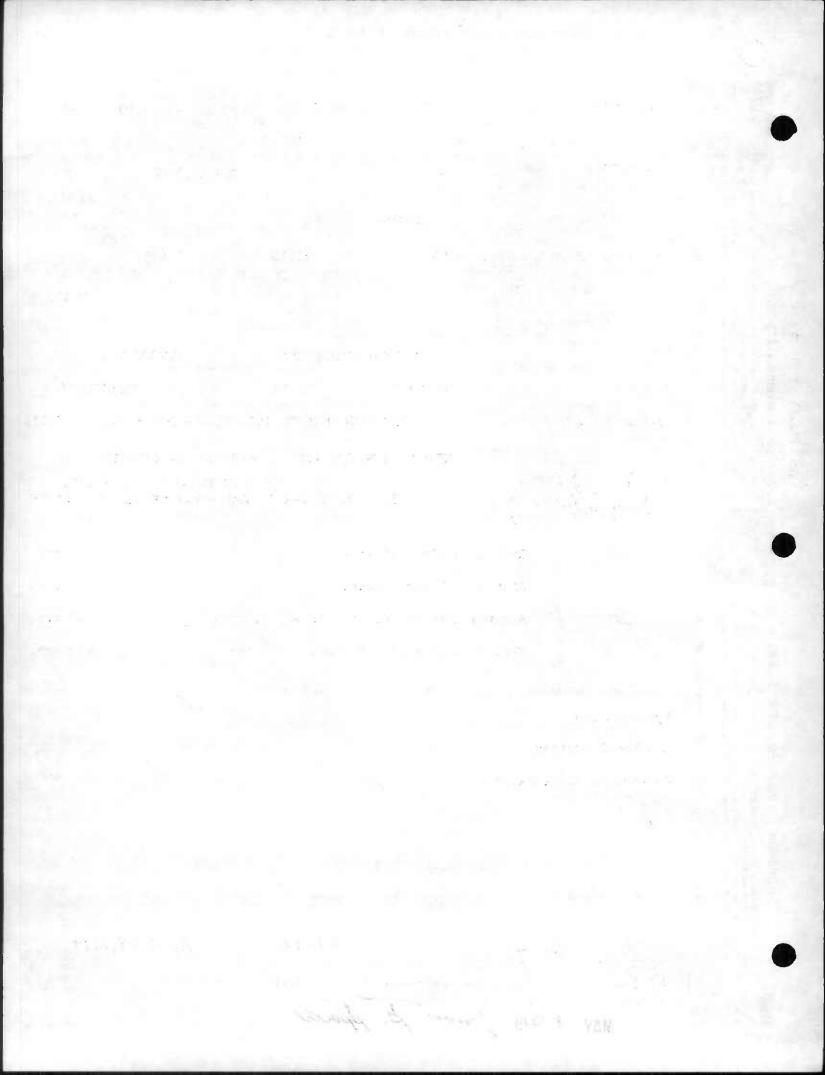
111 Penn Street, Baltimore, Maryland 21201

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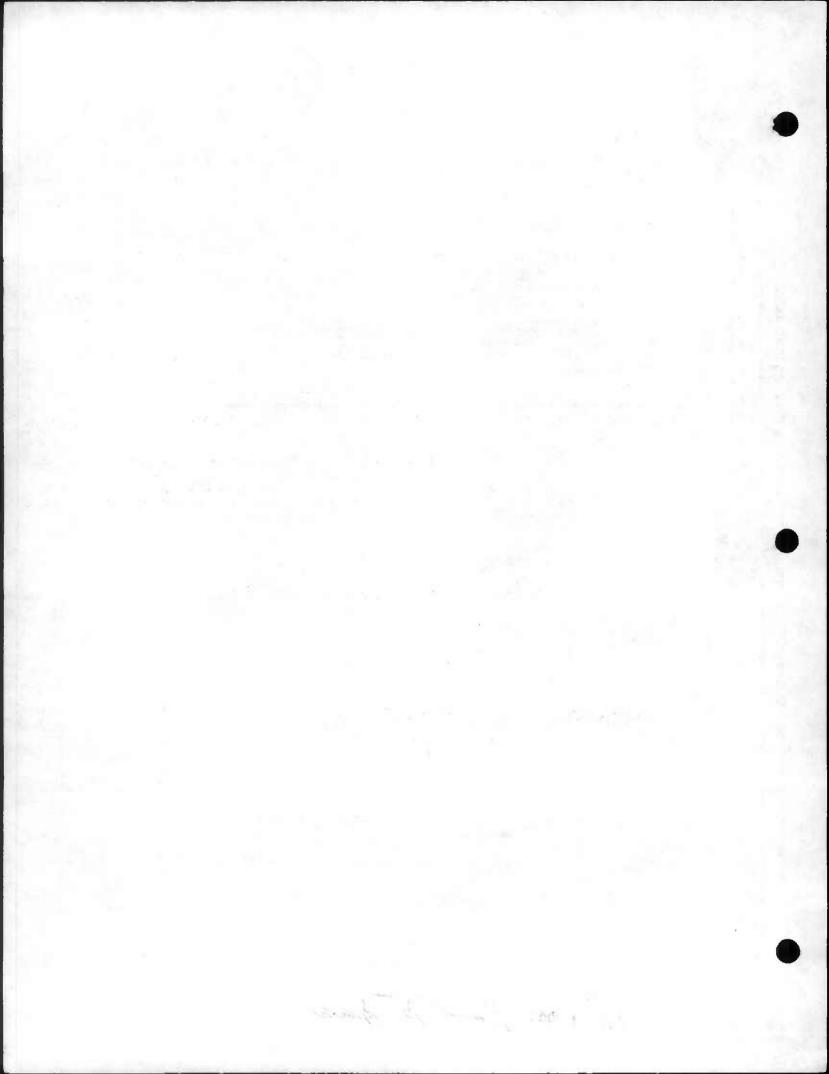
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician DOFTYA 11:55 AM 28, 1999 4c. County of Death /Medical APRIL 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 6. Sex If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months 10 M 20 F Days 215-39-3749 72 Director 15, **BELORUS** Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD 1 Yes 2 □ No Director N/A BALTIMORE 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 5715 PARK HEIGHTS AVENUE #906 21215 **BELORUS** Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: WHITE Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if New 27 is marked other than frast eny injury or other treumatic event, the Median page. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) DISPATCHER TRANSPORTATION 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SOLOMON CHARNAI RISA **GELFAND** 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID PESIN / HUSBAND 5715 PARK HEIGHTS AVE. #906 - BALTIMORE, MD 21215 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEMETERY 4/29/99 REISTERSTOWN, MD 21. Signature of/Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD Approximete Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner Carolyovaseulew disco physicien end s the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of): overany avtery Box 68760, Physician/Medical that initiated events resulting in death) Last The lew requires that the deeth certificate 980 P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown hephreselerson Records, þ 24a. Wes an autopsy performed? 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed Endstage renal 1 Yes 2 No 1 Yes 2 No this certificate Division of Vitai 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 After this funeral 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred Certification: al or Attending I 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours effer To the Funeral Director completely filled in b. 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, end due to the cause(s) and manner steted. odical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29928 Yeur m 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Suffe 610 Pikes ville MD 21208 3635 Old Ot Rd

State Registrar

avid 31. Date filed (Mohth, Day, Mar)

DHMH 16 Rev 6/95

32. Pidpistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 10 04 James E. Peters 15 PM 4b. City, Town, or Location of Daath 4c. County of Deeth 4a Facility Name (If not institution, giva street and number) Anne Arundel Medical Center Annapolis Anne Arundel If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) if Under 1 Year Birthplace (State or Foreign Country) 5 Social Sacurity Number 6 Sev 7. Age (In vrs. lest birthday) 1 ₹M 2□ F Months Days Yrs. 83 11, 1915 Pennsylvania 166-14-8043 Usual Residence of Dacedent 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD Anne Arundel Severna Park 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 111 Severn River Road, #2B 21146 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yas 2 □ No If Yes, Give Yaar or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 Yas 2 XNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Civil Engineer Construction 5+ 12 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fathar's Nema (First, Middle, Last) Edward Miles Peters Blanche Treaster 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Gregory K. Peters (Son) 54611 Madison Road, Spokane, WA 99206 20b. Place of Disposition (Neme of cemetery, crematory or other plece) Dete 20c. Location - City or Town, Steta 20a. Method of Disposition 1 Burial 2X Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 22. Name and Addrass of Fecility 21. Signature of Europa' Safvice Mooney Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onsat and Death Immediata Causa (Final disease or condition resulting in death) ou (monory duation Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to or as a consequence of): Se PSIS Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting In the underlying ceuse given in Pert I. Yes 2□ No 3□ Probably 4□ Unknown 24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 Yas 25. Wes cese referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4☐ Nursing Home 5☐ Rasidence 6☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ P/Outpatlent 3 ☐ DOA 28e. Dete of Injury (Month, Dey Yeer) 27. Menner of Deeth 28d. Describe how injury occurred 8h Time of 28c. Injury et Work? 1 Neturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end menner stated.

29c. License number D24804 29d. Data signed (Month, Day, Year)

tre transpoles mel 2140/

31. Dete filad (Month, -Day, Year) State MAY 1999

29b. Signature and title of certifie

Peterson 600 Rids 32. Ragistrar's Signeture

30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

Registrar

Physician

/Medical

Director

Funeral

by

Completed

Be

Examiner

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryla Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Wedgal Exercise must be not led any page.

Physician /Medical

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To the Hospital or A within 24 hours after To the Funeral Directompletely filled in b

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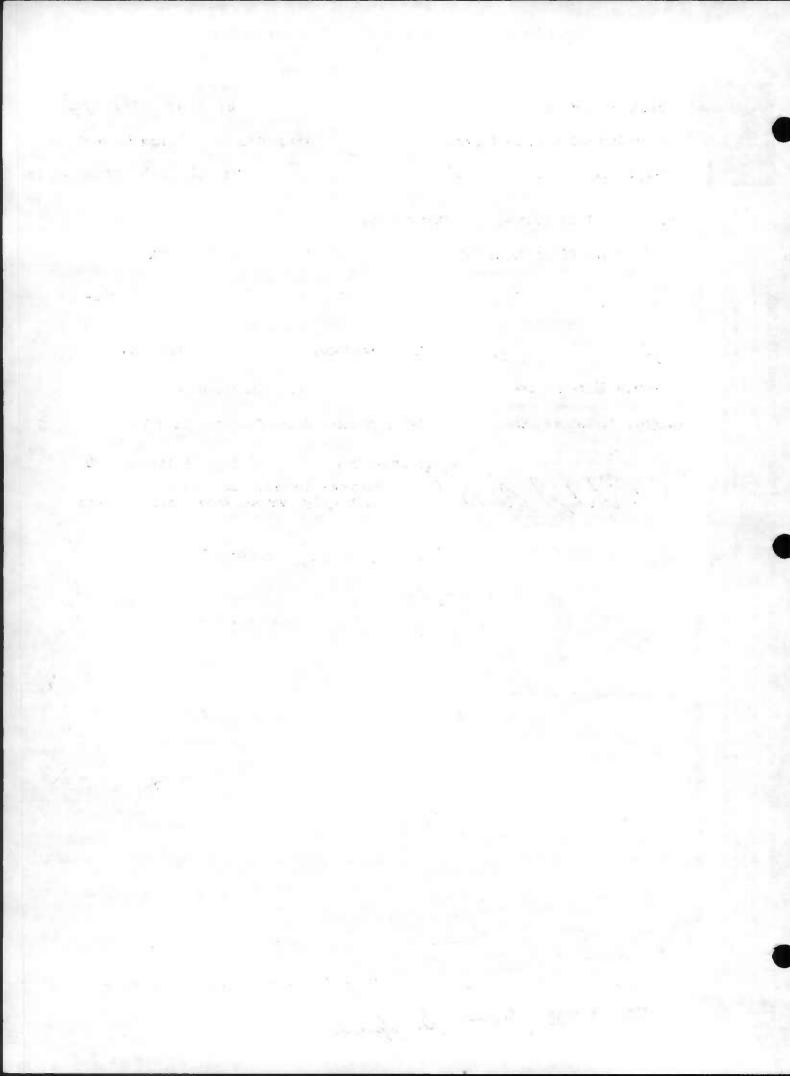
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Medicai

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygi

nd Mental Hygiene Reg. No. 9 144

PHILLIPS					Certificat	e of	Death		Reg. No.9 9		4453		
	_	1. Decedent's Name (First, Middle, L	est)					2. Date of De	eth	Marian	3. Tima of Death		
Physicia /Medica		Alfred Phillips						APRIL	30, 199)9°	3:05 PM.		
Examine		4a Facility Name (If not institution, g	4b. City, Town, or L	ocation of Death	4c. County	of Death							
	N	6514 PARK HEIC	HTS AVE.	APT.C				TIMORE					
Funeral Director		5. Social Security Number 6. Sex 1. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 06/07/1927 Sould Residence of Decedent 1. Security Number 1. Security N											
15-0020 n 72 hours after death with the Maryland "natural", or flame 23s or 28s-1 show after the properties of the prop		10a. State 10b. County					10d. Inside City Limits						
	io	Maryland					1 Yas 2 □ No						
	9	10e. Street and Number		10g. Citizen of What Country?									
	8	6514 Park Height	ot. C	212	215			U.S.A.					
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72 h	ete	15. Decedent's E (Specify only highest of		16a	Decedent's Usu (Give kind of wo	el Occup ork done	oation during most of worl	king	16b. Kind of B	usiness/Ir	ndustry		
yland 212 unid be filed withi Mental Hyglena. arked other than artic event, me.	du.	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done during most of work DO NOT use retired)							
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	m		,						moloon caman	,0,			
	ř	Alfred Phillips 19a. Informant's Name/Relationship	(Tyne Print)	108	Mailing Address	s (Street	Effie Re	gus	or City or Town	State 7	in Code)		
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		29a. Certifier (Check only one) 1. Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner es stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the certain and manner stated.											
Within To the comp		29b. Signature and title of certifier	se number		29d. Date signe								
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2	;	30. Name and address of person who											
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State Registra	-	31. Date filed (Month, Day, Year) MAY 4 1999	Server 32. Regist	rar's Signature	bouls		- 24						

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 6654 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death MAY Dey **Physician** BERNARD J. OUINN. JR. 1999 3:15 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5610 York Rd. #103 Raltimore If Under 1 Year If Under 24 Hrs Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** M 2□ F Days Hours Months 215 34 6612 Yrs. 61 1937 Director Maryland Usuel Residence of Decedent 10a Stete 10b. County 10d. Inside City Limits 10c. City. Town or Location show must be notified at Maryland n/a Baltimore 1 Yes 2 □ No Director 28a-1 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or flams 23a or 5610 York Rd. Apt.# 103 21212 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Detes: 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1XX Never Married 2 Married 1 ☐ Yes 2X No Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Other than 'n Manufacturer / Elementery/Secondary (0-12) College (1-4or 5+) 5+ permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: if Item 27 is marked other the any Injury or other transments Quality Coordinator Instruments 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Bernard J. Ouinn, Sr. Bridget J. Brennan 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Nora M. Hughes / Sister 3206 Northway Dr., Baltimore, MD 20a. Method of Disposition 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Green Mount Crematory 5/5/99 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility CAFA Stephen D. Lohrmann P.A. 21. Signature of Funerel Service License Suple D Johnson 21286 8717 Green Pastures Dr., Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Arberioscleratio Cardiavascular Disease Examiner Due to (or as a consequence of): Examine years pertension physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai Due to (or es e consequence of) Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 3 1 ☐ Yee 2 ☐ No 3 ☐ Probably 3 ☐ Unknown signed t Alcohal Abuse à 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed peen 1 Yes 2000 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1X Yes 2□ No this 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending Investigation e Hospital or Attending n 24 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier **CCertifying Phyeician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. Medicai (Check only one) within 2 To the 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wolfer - Porsey MP AT 24389

State Registrar

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records.

Division of Vital

Attending

DHMH 16 Rev 6/95

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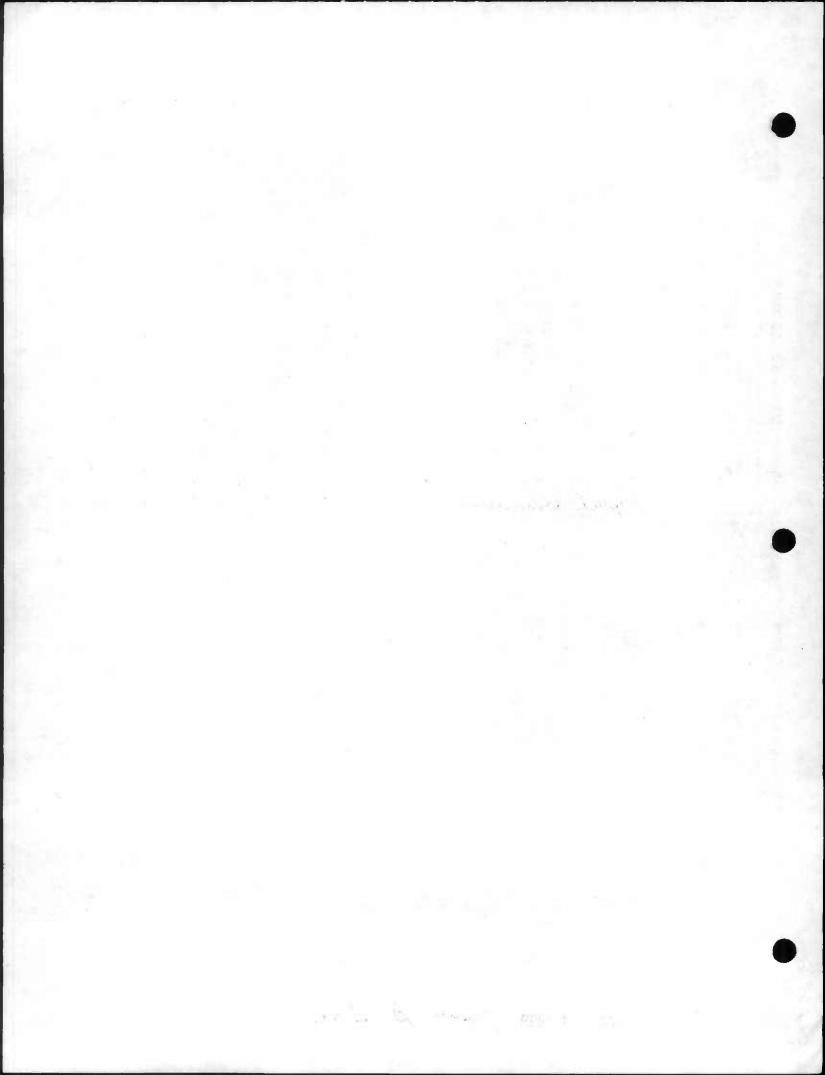
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Dorsey 201 32. Registrer's Signeture

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)

university East

Parkway, Baltimore, MD.

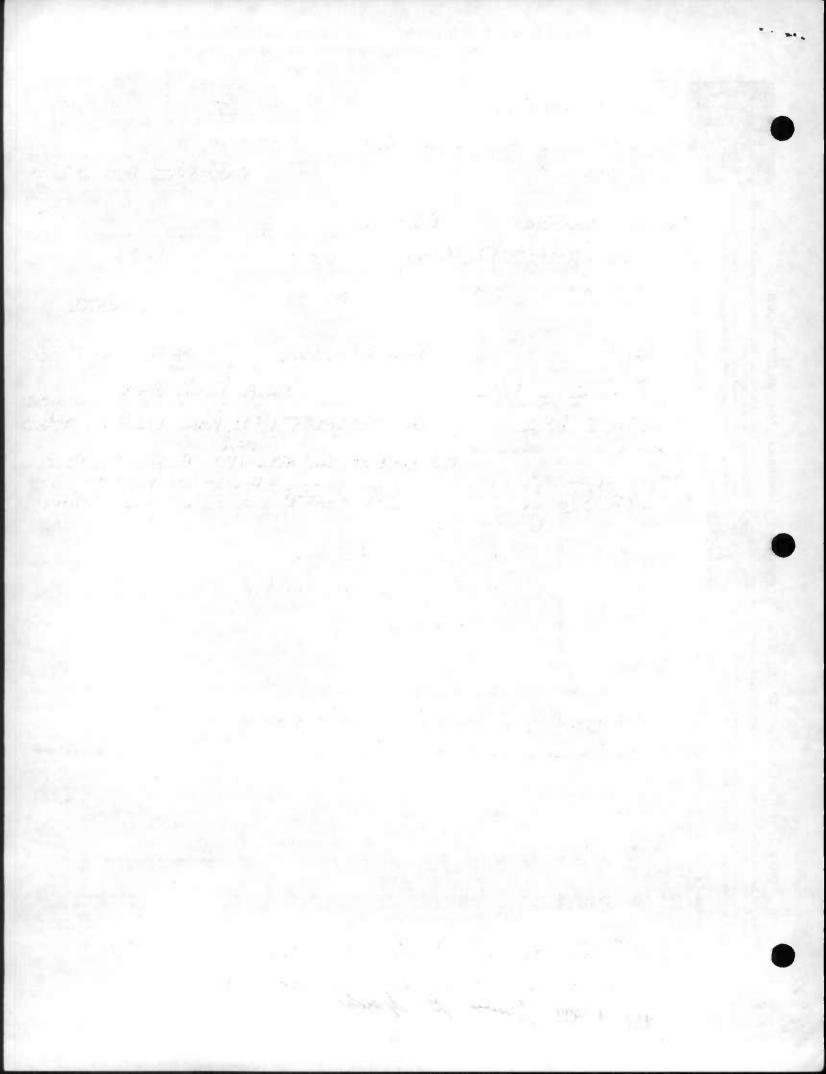


Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month **Physician** 99 850 LSS Rose David /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner RAdoms Cowley 6. Sex Goter 1 Shoch Tauma Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Hours Min. > M 2□ F MORTH LARDENA **Director** 243 4b 6733 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo MARFOR JARY SOL 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? N.S.H 150 21015 120 r deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Maritel Status filed within 72 hours after 1 ☐ Yes ②X If Yes, Give Yeer or Detes: 1 Never Married 200 Married 28 No 1□ Yes 25 No Specify: ZITKW þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12485 HARFORD SACITATION permit. Pages 1 and 2 should be filled Department of Health and Mental Hygis Important: If Neth 27 is marked other 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) ALLZ OCKERHAM 19b. Mailing Address (Street and Number or Rural Route Aumber, City or Town, State, Zip Code) 81015 19e. Informent's Neme/Reletionship (Type, Print) O BILATR PRIAGO 20c. Location - City or Town, Stete KOAO GLORIA 20b. Plece of Disposition (Name of cemetery, crematory or other place) MAND 20a. Method of Disposition Burial 2 Cremation 3 Removal from State BURIR 4 Donation 5 Other (Specify) EMOREL GEROLOS 1990 WESTERO 22. Name end Address of Fecility

22. Name end Address of Fecility

CHASI 21. Signate BELAIR, P.A. 3,020 EVANS FUNERAL FORSE 3 DEWPORT DRIVE 1ARILAN 50 discussions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, and caused line. 23a. Pert 1. Enter the diseese, or companions shock, or heert failure. List only Approximate Intervel Between **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical myocordial Examiner Due to (or es e consequence of): Physician/Medical Examiner 13 ystem Orga ettending physicien end for use es the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequence of): septicemia Due to (or es e consequence of): resulting in death) Lest signed by the e Division of Vital Records, P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? Atral For lato ours efter death.

eral Director: After this certificate has filled in by the funeral director, page 2. 1 Yes 2.2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was cese referred to medicel examiner? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ≦ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury et Work? Certification: 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral C ★S Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and menner stated. edicai 29a. Certifier (Check only one) 29b. Signetune and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D005359X care attending 30. Name and address of person who completed cause of death (Item 23e) (Type Print) Baltimore 2 5. Green Barrow MD 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State 1999 Registrar **DHMH 16 Rev 6/95**



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2 Date of Death Month Rosen moshe 1626 1999 April 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth THE JOHNS HOPKINS HOSPITAL Baltimore City If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) N/A 6. Sex 1 → M 2 □ F Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Yrs. 344-38-8111 66 JAN. 1,1933 ROMANIA Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No MD N/A BALTIMORE 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 500 W. UNIVERSITY PKWY. #10-N 21210 U.S.A. 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, spacify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UNIVERSITY PROFESSOR EDUCATION 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) KALMAN ROSENBERG OSNAT (UNKNOWN) 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) LEA ROSEN / WIFE 500 W. UNIVERSITY PKWY. #10-N / BALTIMORE, MD 21210 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) BETH TFILOH CONGREGATION 4/29/99 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer failure. List only one ceuse on each line. Approximate Interval Between Onset end Death Immediete Ceuse (Finel disease or condition resulting in death) 4 months Metastatic carcinome Due to (or es e consequence of): Pulmonary embolus Due to (or as e consequence of): month Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Sepsis 1 month Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: 1,55 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work?

Physician /Medical Examiner

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Pages 1 and 2 should be filed within 72 hours aftar death nant of Haalth and Mental Hygiene.
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altimore, Maryland 21215-0020

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Examiner burial-tran and that the death certificate be axe physician Physician/Medical thal as usa for

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Division of Vital Records,

Hospital or Attending

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by

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

5 Pendina

K. Fairbank

MAY

Investigation

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State Registrar

Medical

12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29b. Signature end title of certifier 29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

april 27, 1999

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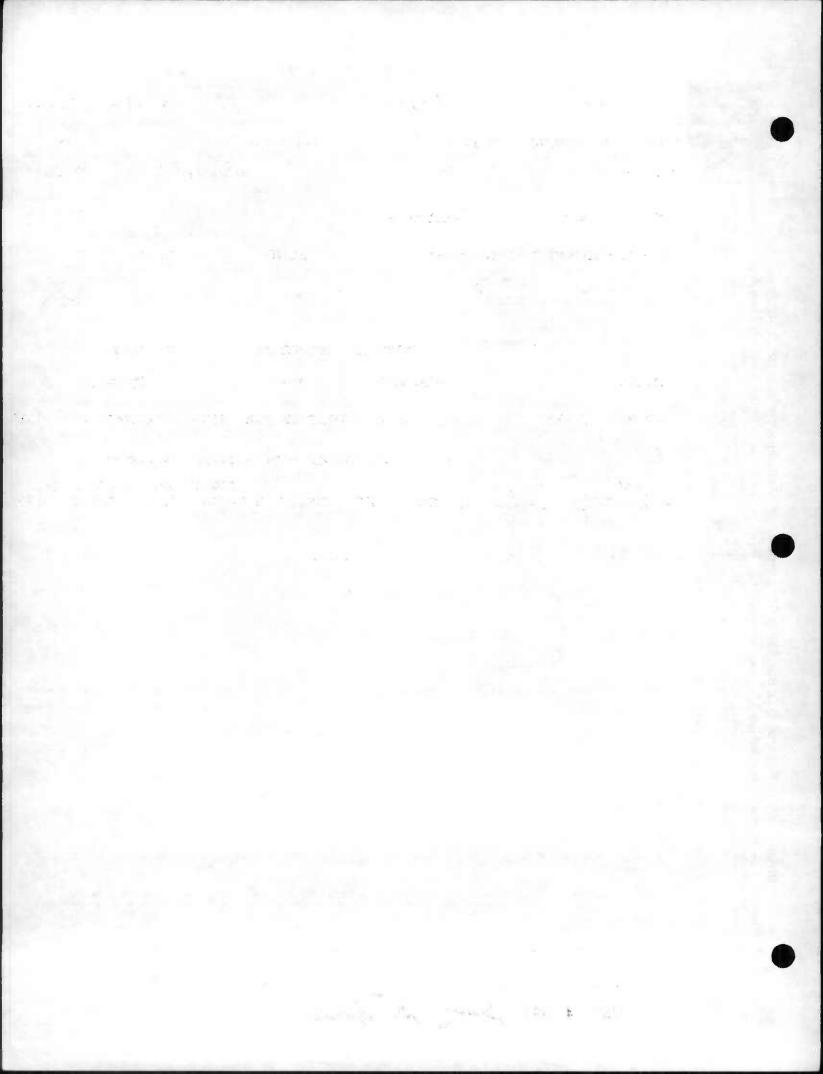
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

Baltimone, mo K. Fairbanks, mD _ 600 N. Wolfe Street r

31. Date filed (Month, Day, ear)

32. Registrar's Signature



Box 68760. of Vital Records. Division **Physician**

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filed within 72 hours after tal Hygiene. d other than "natural", or it event, the Madical Examin

Pages 1 and 2 should be fill ment of Health and Mental H sert; if Nem 27 is marked off lury or other traumatic even

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Baltimore, Maryland 21215-0020

Physician/Medical Examiner physician and the burial-transit 98n Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. by should Completed page 2 s 25. Wes case referred to medical examiner? Medical Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After or Attanding 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 T Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and due to the cause(s) and menner stated.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner stated. completely (Check only one) To the

State Registrar

31. Dete filed (Month, Dey, Year) 4 1999 MAY

29b. Signeture and title of certifier

K. Willsmy

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

KANTHI WICKS HD, 4600 WILKENS AVE BALT, MORE MD 21229 32. Registrer's Signeture

29c. License number D40369 29d. Date signed (Month, Day, Year)

DELLE SALVERS

Division of Vital Records, P.O. Box 68760,

the bunal-transit and physician usa as ed by the e signed by I certificate has birector, page 2 s funaral director, this After or Attending after death. To the Hospital or Atte within 24 hours aftar de To the Funeral Directo completaly filled in by the

Physician

/Medical

Examiner

Director

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permit. Peges 1 and 2 should be filed within 72 hours affer copertment of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Hedgal Exercised

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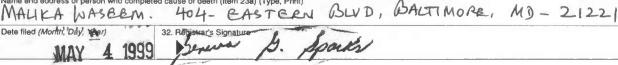
Medical

Saltimore, Maryland 21215-0020

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State Registrar 31. Dete filed (Morth, Day, Year)

29b. Signature and title of certifier

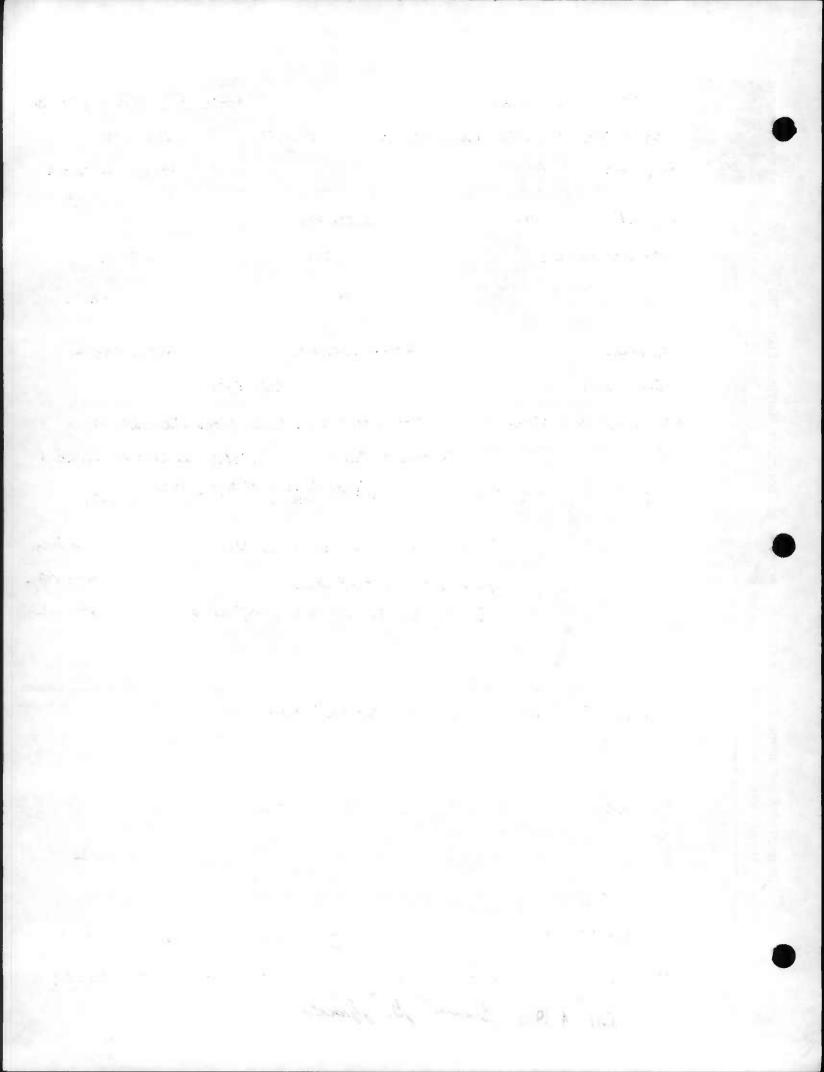


30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Dey, Year)

D-38754. 04-30-



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dele of Deeth 3. Time of Deeth Month Tara Lynn Redding 6:20am MAY 1 1999 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 9, 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) 10 M 20 F Deys Min 30 215-76-3377 Yrs. Maryland Usual Residence of Decedent 10e Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Owings Mills Baltimore Maryland 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code U.S.A. 21117 11424 Reisterstown Road 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 ☐ Merried White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Own Home 12th Grade Homemaker 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Linda M. Blick P. Redding, II James 19e. fnforment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7590 Boulder Drive. Sykesville, MD 21784 James Truit Redding (brother) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removel from State 5/4/99 Sykesville, Maryland Lake View Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD

23a. Part1. Enter the disease, of complications that caused the deetly. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onsel end Death Immediate Cause (Final diseese or condition resulting in deeth) Respirator ARDS Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury thal initieted events resulting in deeth) Lest Due to (or es e consequence of): Sepsis Due to (or es e consequence of): pancruatitis 23b. Did tobacco use contribute to the cause of death? Pert fl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28b. Time of 28d. Describe how Injury occurred 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. fnjury et Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of fnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one)

that the death certificete be executed Division of Vital Records, P.O. Box 68760, The law requiras Physician: Hospital or Attending **Physician**

/Medical

Examiner

Directo

Funeral

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Completed

Funeral

Director

7 is marked other than "natural", or flems 23a or 28a-f show traumatic avent, the Medical Examiner must be notified at

12 should be filed within 72 h end Mentel Hygiena.

permit. Pages 1 and 2 should be file Depertment of Heelth and Mentel Hy Important: If Ilem 27 is marked othe eny linjury or other traumatic avent page.

Physician /Medical

Examiner

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the Maryland

Registrar

. Breiner MD 32. Registrer's Signature

une Brunes No

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

29b. Signature end title of certifier

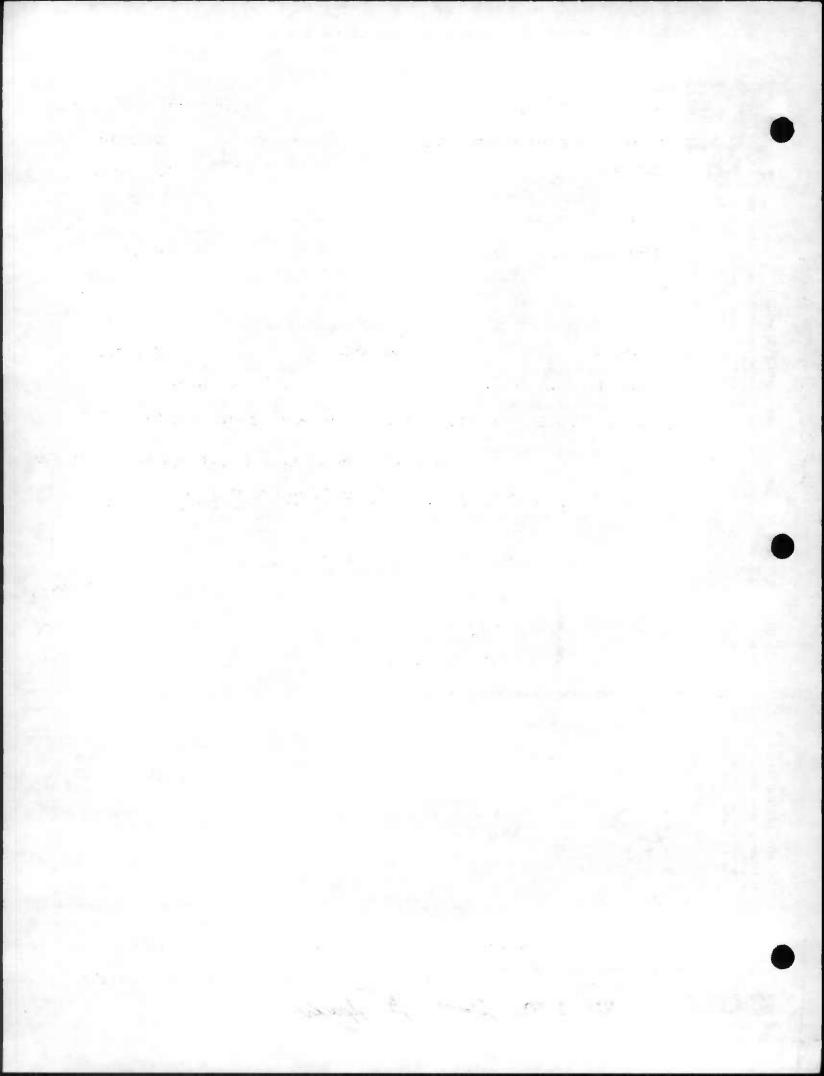
1205 York Rd St 32c Lutherville

29c. License number

040208

29d. Date signed (Month, Day, Year)

21093



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death April 26, Day 1999 11:51 p.m. Rukmani Devi Rajput 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Silver Spring Montgomery Holy Cross Hospital Hours Min. 8. Deta of Birth (Month, Day, Year) April 2,1909 If Under 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foraign Months Days 1 M 200F 90 Country) India Yrs. 217-13-8841 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits Yas 2 No Silver Spring Montgomery 10e. Street and Number 10f. Zio Code 10g. Citizan of What Country? 20904 India 606 Chichester Lane Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedenf Evar in U,S. Armed Forces? 14. Race - Amaricen Indian, 11. Marital Status Black, Whita, atc. 1 Yas 2\No If Yas, Giva Year or Datas: 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: Asian Indian 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Ø^{College (1-4or 5+)} Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Ratni D. Binhal Sitaram Binhal 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Retationship (Type, Print) Roop Singh Rajput/Son 606 Chichester Lane, Silver Spring, Maryland 20904 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2☐Cremation 3 ☐ Removat from State
4 ☐ Donation 5 ☐ Other (Specify) 5/1 Laurel, Maryland Baltimore Washington Cr. e of Funesal Service License 22. Nama and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707

Approximate allure. List only one cause on each line.

Approximate Approximata Interval Batween Onsat and Daath STROKE Sudden Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? Respiratory FAILIRE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to complation of causa of death? CARdiogenic Short 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 No 25. Was case refarred to medical 26. Place of Death (Check only ona) 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stata

MD

Directo

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Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Mi Department of Health and Mental Hyglens. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f. Is any injury or other traumatic event, the Medical Examinar must be notified bods.

Saltimore, Maryland 21215-0020

Examiner physicien end s the burief-transit Physician/Medical signed by the e by Completed Certification:

at or Attenders.

Its effer deeth.

Aret Director: After this of the funeral of To the Hospital or Atterwithin 24 hours effer ded To the Funeral Director completely filled in by the

State

Box 68760 Division of Vital Records, P.O.

> S.K. G.PTA MO 31. Data filed (Month, Day, Year) MAY 0 4 1998

5 Pending investigation

6 ☐ Could nof be

1 Naturat

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signatura and title of certifier

30. Nama and address of person who completed ceusa of death (Item 23a) (Type, Print) 9801

GeoRgIA 32. Fegistrar's Signatura

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

#220 Silver Spring MD 20902 RUE

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0 32332

1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29d. Data signed (Month, Day, Year)

Registrar

Y TOTAL

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Yee **Physician** Paul F. Smith, Sr. 29, 1999 4c. County of Death APRIL 01:10 AM /Medical 4a Fecifity Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore # Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | OCt. 13, 1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** tXM 2□ F 75 Yrs Director 218-18-0952 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryrai Haalth and Mental Hygiana.

tem 27 is marked other than "natural", or flems 23a or 28a-f show other treumatic event, the Madical Examener must be nortified. NYes 2 No Maryland N/A Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3524 Roland Avenue 21211 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

†\C\tag{Yes} 2 \subseteq No H Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2\O\No Specify Specify: by white 3℃Widowed 4 Divorced Year or Dates: WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Engineer Borden Company Unknown 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Haalth a Janet Trimble 3004 North Branch Lane Baltimore, Maryland 21234 Daughter 20b. Plece of Disposition (Neme of cemetery, cramatory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Pages nant of t 0 1 ☑ Kurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: If eny injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Dulaney Valley Mem Grdn | 5/3/99 | Cockeysville, MD 21. Signature of Funeral Service Licent 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 214 23a. Part1. Enter the disease, or completions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only of I cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final LUNG CANCER disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner requires that the death cartificate be executed physician and the burial-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 edical Due to (or as a consequence of) usa as i attending Physician/M 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yee 2 No 3 Probably 4 Unknown signed t þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy peed completion of cause of death? has page 2 1 Yes 2 X No 1 ☐ Yes 2 ☐ No cartificata 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2₺ No 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury st Work? Certification: Aftar 1 Netural 5 Pending investigation after death. 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 24 hours e Hospital 12 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) To the Vithin 2 29d. Date signed (Month, Day, Year) 29b. Signature apende of codifier 29c. License number 4-29-D37254

State Registrar

BOON P. LIM, M.D., tate
31. Date filed (Month, Day, Year)
MAY 0 4 1999

7601 OSLER DRIVE 82. Registrer's Signature

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

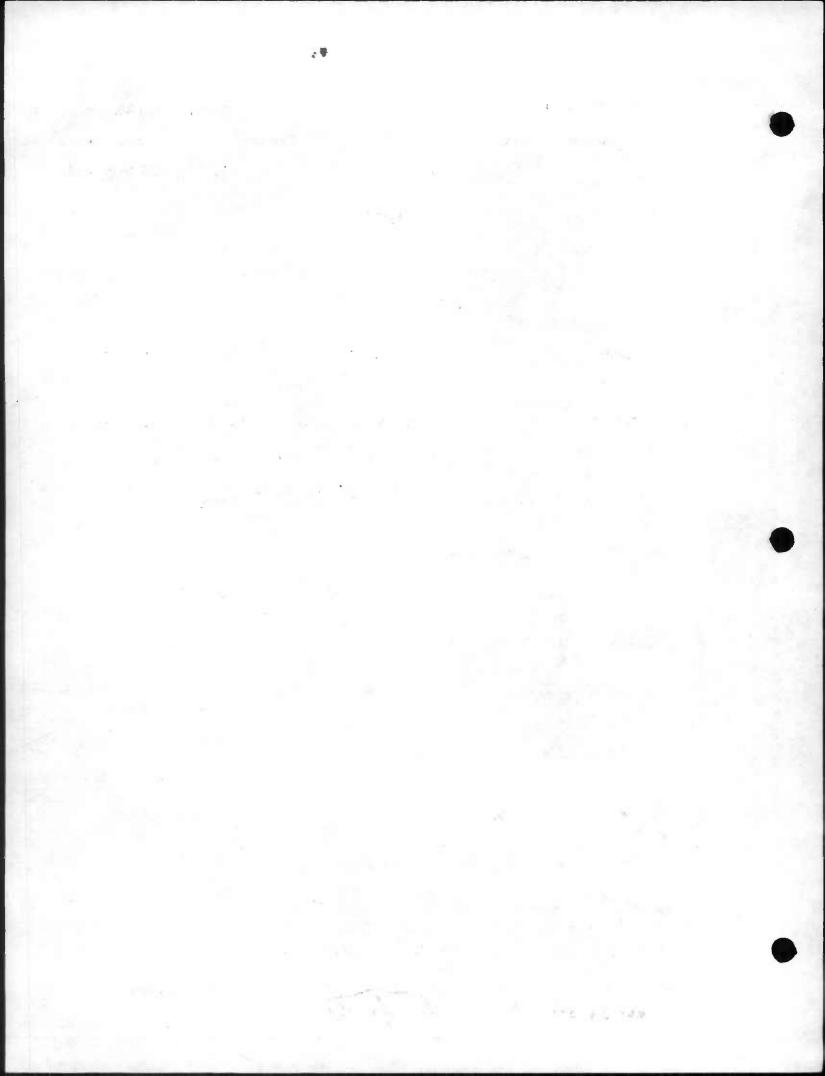
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TOWSON, MARYLAND 21204



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#5 perFH G771 5/4/99 EW 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** EISIE Salganik /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** birthday) If Under 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Numba 7. Aga (In yrs. last birthday) **Funeral** 1□M 20 F Months Days Hours Min. 218-12-Yrs. 75 **Director** JUNE 25,1923 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yas 2 ♥ No Director BALTIMORE BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7211 PARK HEIGHTS AVENUE #402 21208 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Meniel Hygiene. Important: If itsm 27 is marked other than "natural", or items 23s and injury or other treumatic event, the Medical Examinations. Funeral 12. Was Decedent Ever in U,S Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Yaar or Datas: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No WHITE Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COPYWRITER ADVERTISING 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) CARL FLOM RUTH **BLIIM** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Code) ALVIN SALGANIK / HUSBAND 7211 PARK HEIGHTS AVE. #402 - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OHEB SHALOM MEMORIAL PK 5/2/99 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liçense 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. van 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failura. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** · Adult Respiratory Distress Syndrome /Medical Immediate Causa (Final disease or condition resulting in death) Fire days Examiner Physician/Medical Examiner attending physician and for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen completion of cause of death? has 2 X No 2 No 1 🗆 Yes cartificete or Attending Physician; director. 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one, To 1 Yes 2 No Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1) Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation • Funerel Director: Aft bletely filled in by the fur 1 Tes 2 No 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) within 2. 29c. License number 29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatura

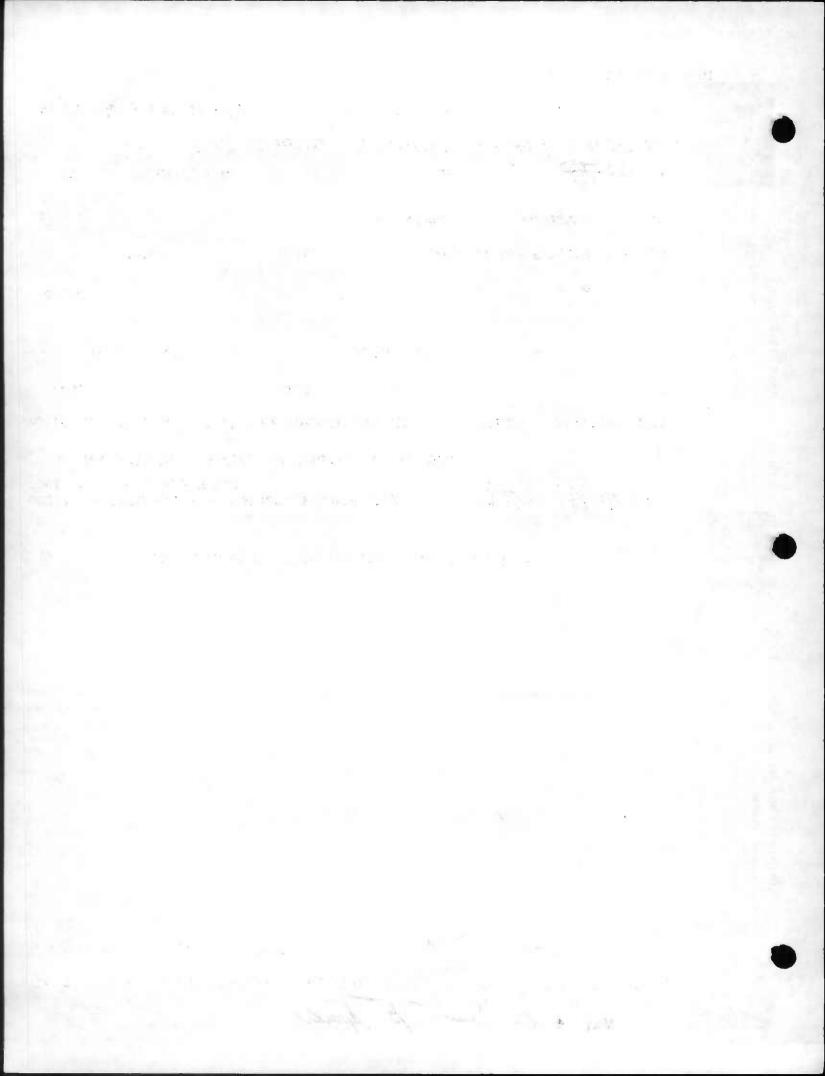
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Tower 110 Baltimore marvland 21205

State Registrar

31. Date filed (Month, 2)

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Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** ALBERT. AARON STEIN April 1314 1000 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Baltimore the pital of Baltmore Since N/A If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Months, Deys, Year) DEC 22,1907 6. Sex 1X M 2□ F Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 91 PA **Director** 214-03-0034 Usual Residence of Decedent 10e. Stete 10c. City, Town or Location 10d. inside City Limits 10b. County The marked other than "natural", or items 23a or 28a-f show trainmatic event, one Medical Examiner invest or notined at 1 Yes 2 No N/A BALTIMORE 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zin Code 21215 6806 FAIRLAWN AVENUE U.S.A. 14. Rece - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11 Meritel Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Specify: þ 3 Widowed 4 □ Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 PRESSER CLOTHING MANUFACTURING 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maidan Sumema) parmit. Pages 1 and 2 ahould be Ospartment of Health and Mental Important: If Nem 27 is marked or STEIN **SMELKINSON** FRANK TDA 19e. informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) MARLENE BORMEL / DAUGHTER 6804 FAIRLAWN AVENUE - BALTIMORE, MD 21215 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □Removal from State OHEB SHALOM MEMORIAL PARK 4/30/99 REISTERSTOWN, MD 4 Donation #5 Other (Specify) 21. Signature 22. Neme end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD er the distance, or conheart failule. List con e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximeta Intervel Between Onset end Deeth Physician /Medical Examiner Due to (or as a consequence of) Physician/Medical Examine enmonia be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Box 68760, Renal Failure rding physician that initiated events resulting in death) Last # The lew requires that the death Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert t. 23b. Did tobacco use contribute to the cause of death? the 1 Yes 2 No 3 Probably 4 Unknown signed by Heart Facture 8 24b. Wara autopsy findings evelleble prior to completion of cause of daeth? 24a. Was an autopsy performed? Completed need hes : 1 Yes 22 No 1 Yes 2 No certificate or Attending Physician: 25. Was casa rafarred to madical exeminer? Be 26. Placa of Daath (Chack only one) Hospitel: Other: 4 Nursing Home 5 Residance 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpetient 3 DOA this 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred Certification: Aftert 5 Pending investigation death. 1 Yes 2 No eral Director: A filled in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours or To the Funeral Completely filled 1 Certifying Physician: To the bast of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) end menner stated. 29a. Cartifiar (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of ca 29c. License number AS2402321-DK-ZASApril 28, 1999

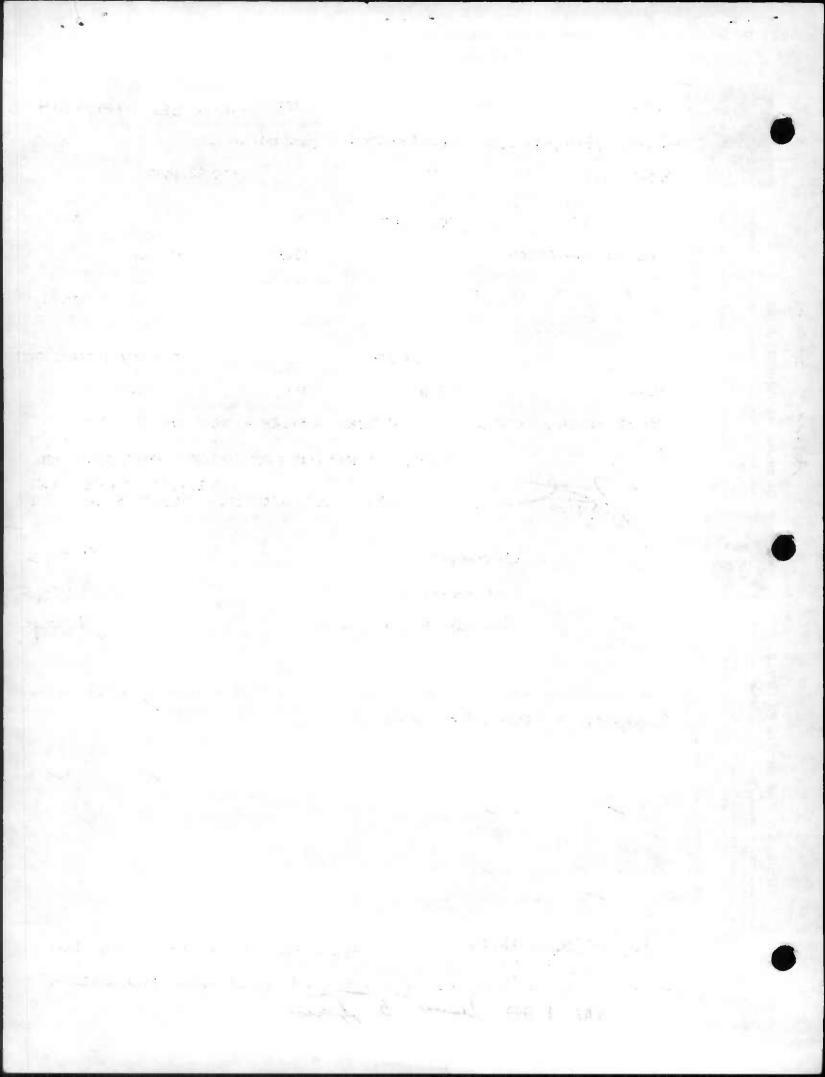
complated causa of daeth (Item 23a) (Type, Print)

32. Regist ar's Signeture

-2401 W. Belucidere Rd, Baltimore, MD 21215

State Registra

David Kanfman 31. Date filad (Month, Day, Year)



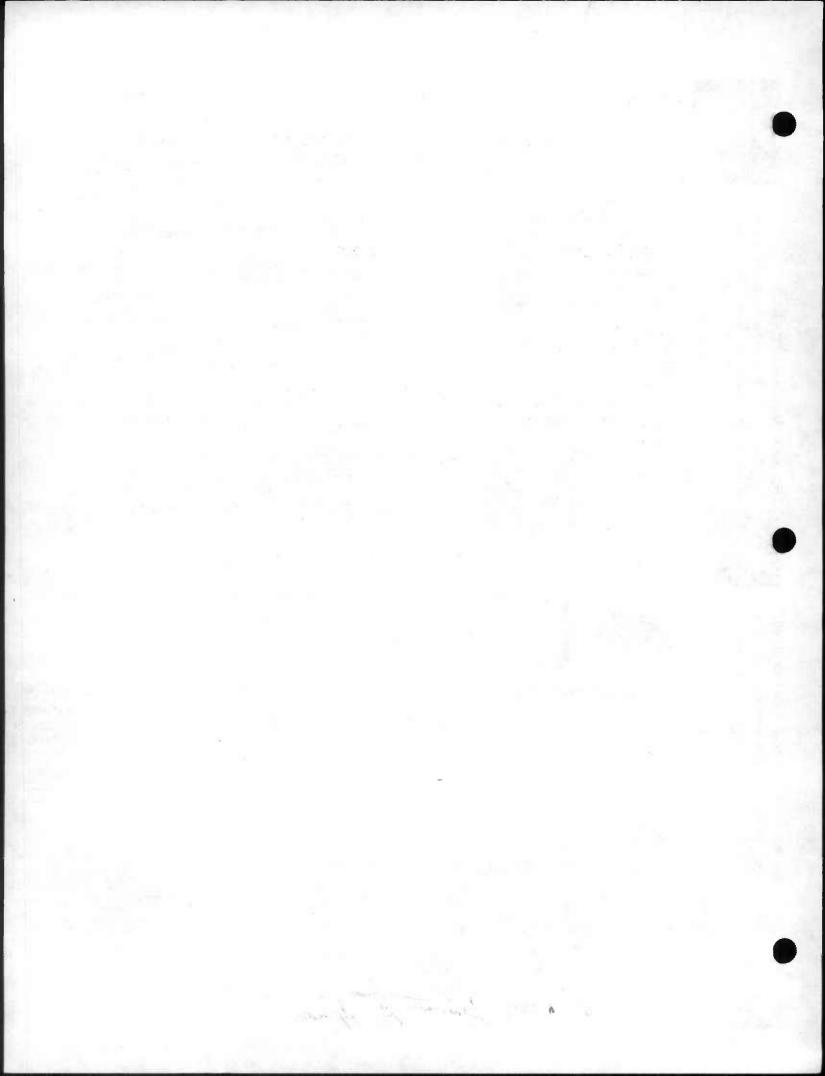
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State of Maryland / Department of Health and Mental Hygiene 9 14464

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State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** 0730 MAY Gabriel Serio /Medical 4e. Fecility Name (If not institution, giva street end numbar) 4b. City, Town, or Location of Death Examiner Church Home & Hospital Baltimore If Under 1 Yaar if Under 24 Hrs. 8. Data of Birth
Hours Min. (Month, Dev. Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthpleca (Stata or Foreign Country) **Funeral** Days Months 1 M 2 □ F Director 215-12-7340 78 01/20/1921 Baltimore, MD Usual Residence of Decadant 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ŏ 23a 15-0020 528 Holtzman Ct. Funeral 21231 USA 12. Wes Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 11. Manital Status 14. Race - American Indian. Bleck, White, etc. Armed Follows:

1 ☑ Yes 2 ☐ No if Yes, Give Yaar or Dates: WWII 1 ₹ Never Married 2 Married ò 1 ☐ Yas 2 🗷 No by Specify: 3 ☐ Widowed 4 ☐ Divorcad White Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2121 within 7 Elementary/Secondary (0-12) College (1-4or 5+) 6th Tailor Clothing laryland 2 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be ould be Mentel F is marked Fedele Serio 2 Josephine Mesi 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Important: if item 27 is any injury or and Daniel J. Serio/Brother 6721 Brentwood Avenue Baltimore, Maryland 21222 20b. Placa of Disposition (Name of cometery, cremetory or other place 20e. Method of Disposition 20c. Location - City or Town, Stete cometery, cremetory or other place)
Crownsville Cemetery 1 Buriel 2 ☐ Cremetlon 3 ☐ Removal from State 5/7/99 Crownsville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility David J. Weber Funeral Homes, P.A. 401 S. Chester St. Baltimore, Maryland 21231 23a. Part1. Enter the disaasa, or completions that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intarval Batween Onset end Death **Physician** /Medical Immediate Ceuse (Finei disaesa or condition resulting in death) . MASSIVE CEREBROVASCULAR ACCIDENT 2 Weeker Examiner HYPERTENSIVE HEART DISEASE Examine Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest and Box 68760. physiclan The law requires thet the death certificete be Physician/Medicai Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown CONGESTIVE HEART FAILURE Division of Vitai Records. P ATRIAL FIBRILLATIONI CHRONIC 24b. Were autopsy findings eveileble prior to completion of causa of deeth? 24e. Wes en autopsy performad? Completed 1□ Yes 2 No 1 Yes 2 No or Attending Physician: Be 25. Wes case refarred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Dinpatient 2 □ ER/Outpetient 3 □ DOA this 28e. Data of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending investigation 1 DNetural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Plece of injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide in 24 hour. the Funeral Direction 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end mannar stated. 29a. Certifler To the Hosp within 24 ho To the Fune completely fi Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) And Speciality

State Registrar

NAVARRO.

30. Name end eddress of person who completed causa of deeth (Item 23e) (Type, Print)

MD.

100 N. Broadway, Baltinore, Mayland 21231

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** 3:50 Am 1999 William W Smith /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner osedale Baltimore Franklin Hospital enter , ware If Under 1 Yeer Months Days If Under 24 Hrs. 5. Social Security Number Birthplece (Stete or Foreign Country) 6. Sex 7. Age (n yrs. last birthday) 8. Date of Birth (Month, Dev. Year) **Funeral** XIXM 2 F Hours 214-14-8882 76 Director June 16,1922 Maryland Usuel Residence of Decedent the Maryland 10d. Inside City Limits 10a Stete 10b County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at Md. Baltimore ESSEY 1 ☐ Yes 2X No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 810 George Ave. 21221 IISA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Btack, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist American Can Co. 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental George Smith Marie Feldman 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Duane Grove /son-in-law 802 Delray Court Forest Hill Md. 21050 27 Important: If Item any Injury or othe 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) OAk Lawn Cemetery 5/6/99 Baltimore Md. 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 23a. Pert1. Enter the disease, or compil ations thet caused the deeth. De not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only of cause on each line. Approximate Intervel Between Onset and Death **Physiclan** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner otic 201 attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert t. signed by the a 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown erebrovascular Accident þ 24b. Were autopsy findings eveileble prior to completion of cause of death? Completed Carcino-Embryonic Antigen Recent 24a. Was an eutopsy is cartificata has t director, page 2 s Hypertension 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 24 hours aftar death. Funeral Director: After this carifice 25. Was cese referred to medical examiner? 26. Plece of Deeth (Check only one) Be Hospitel: 1 🕱 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Yes 2 No funeral 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) end menner stated. Medical 29a. Certifier 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number 30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print)

9000 Franklin

32. Registrer's Signature

Square Drive

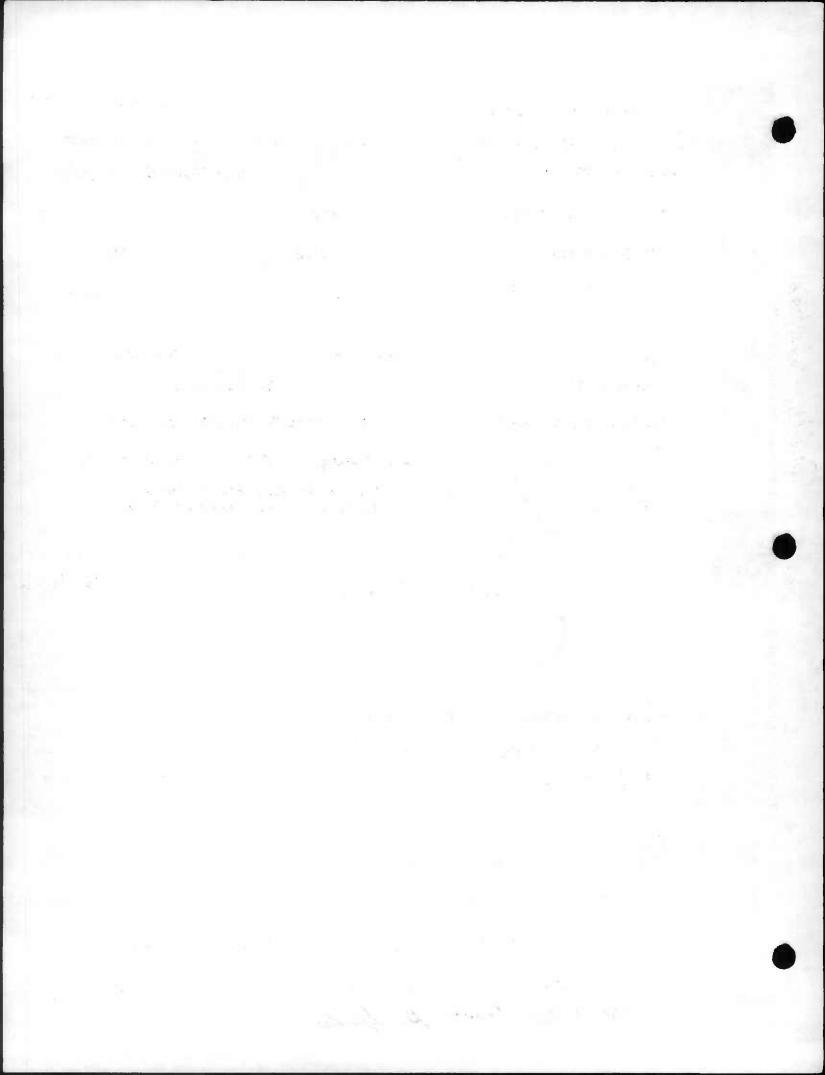
Baltimore, Maryland

State Registrar or Savitha SHivananda

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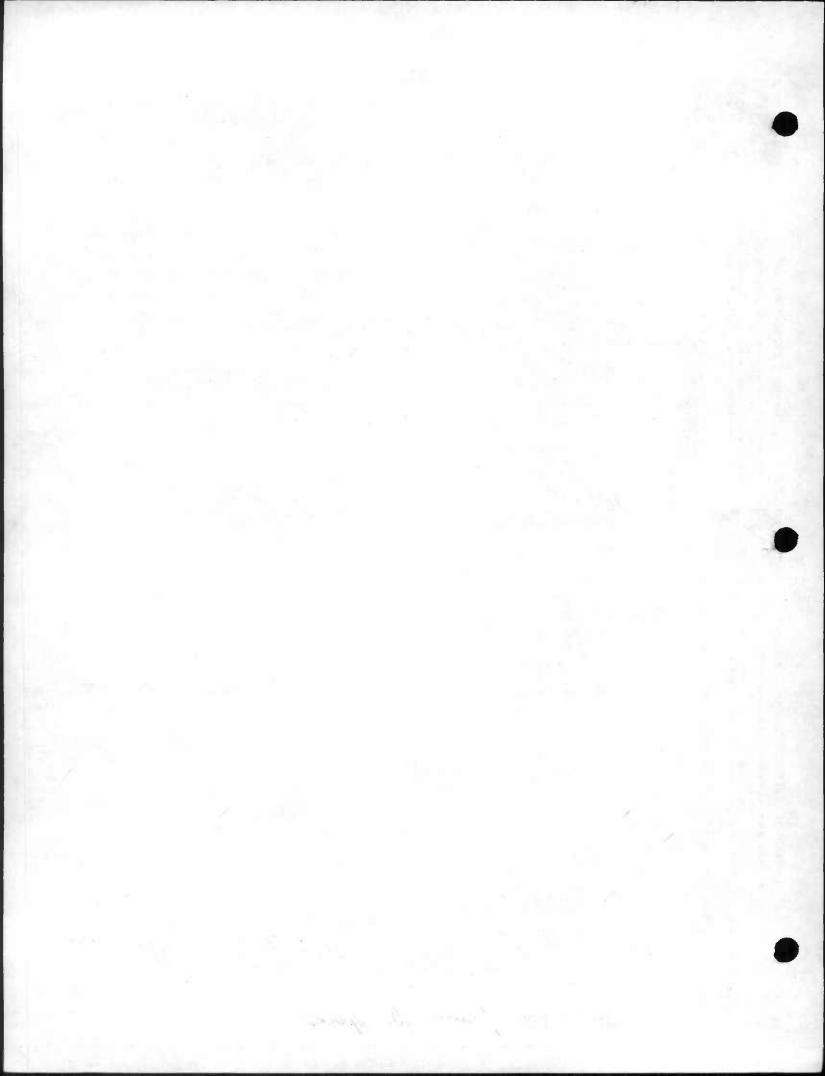
State of Maryland / Department of Health and Mental Hygiene 🛭 🔍 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Juanita Snoots 3, 1999 May 7:00 AM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1112 BAKER AVENUE BALTIMORE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M XX F Director 232-54-4420 63 3/13/1936 W. VIRGINIA Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at MD BALTIMORE **Funeral Director** BALTIMORE 1 ☐ Yes 2 ₩ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1112 BAKER AVENUE 21207 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. Peges 1 and 2 should be filed within 72 hours after to end of Health and Mental Hydjena.
ntt. if item 27 is marked other than "natural", or item into or other traumals avent, the lies of 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Merried 20 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: by WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) OPERATIONS OFFICER SERVICE CENTER CORP. 17 Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ERNEST KUYKENDALL MARY (SPITZER) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) LAWRENCE SNOOTS (HUSBAND) Important: If itam 27 any injury or other tr. pnce. 1112 BAKER AVENUE BALTIMORE, MD 21207 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) permit. Pege Department LAKEVIEW CEMETERY 5/5/99 SYKESVILLE, MD 21. Signators of Funeral Service Lines 22. Name and Address of Facility Witzke FUneral HOmes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical FARS Examiner Examine ician and burist-transit The lew requires that the death certificate be axecuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): physician s the buris Box 68760, Physician/Medical Due to (or es e consequence of): USB as 1 signed by the at the datached for 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Tes 2 No 3 Probably 4 Unknown of Vital Records, Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? has page 2 2 No 2 No 1 Yes Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attanding 1 Naturel 5 Pending investigation 1 Yes 2 No r death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29a. Certifier completely (Check only one) within 2 To the \$ 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) BASTIMONES MD 00 AUL

Registrar **DHMH 16 Rev 6/95**

State

31. Dete filed (Month, Day, Year)

32. Registrer's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #23a PER MD G784 6/14/2000 AH Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** 29 1999 Christina Shawker April 20:45PM /Medical 4a Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Agnes Hospital Baltimore 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar If Undar 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** 1□ M 2X F Months Days Hours Min Yrs. Director 212-28-2643 80 AUG 16, 1918 Canada Usual Residence of Decedent with the Maryland permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haalth end Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Catonsville 1 Yas 2 No MD Baltimore Directo 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 331 Whitfield Road 21228 USA Funeral Was Dacedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 12. Was Dacedant Evar In U,S. Armed Forcas? 14. Race - American Indian. Black, Whita, atc. 1 ☐ Yas 2 ☐ XNo If Yes, Giva Yaar or Datas: 1 Navar Marriad 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast greda complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 11 Homemaker Domestic 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Franciska Huber Frank Weber 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Calvin H. Shawker/husband 331 Whitfield Rd. Catonsville, MD 21228 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 1 Burial Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 04/30/99 Metro Crematory, Inc. Baltimore, Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 299 Frederick Rd. Balt:
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onsat and Death Physician /Medical Immediata Causa (Final disaasa or condition resulting in death) **PNEUMONIA** Days **Examiner** Dua to (or as a consaguanca of): Examiner CEREBROVASCULAR ACCIDENTS Years attending physicien and for use as the burial-transit Sequantially list conditions, if any, leading to immadiata causa. Enter Undarfylng Ceuse (Diseese or Injury that initiated avants rasulting in daath) Last Dua to (or as a consaquenca of): certificate be execu P.O. Box 68760 Physician/Medical CEREBRAL ATHEROSCLEROTIC DISEASE Years Dua to (or as a consequence of) signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Munknown Tha law requires that Coronary artery atherosclerotic disease Division of Vital Records, by 24b. Were eutopsy findings available prior to completion of cause of death? certificate has been si rector, page 2 should I Completed 24a. Was an autopsy performad? Possible Creutzfeldt Jakob disease CHRISTINA SHAWKER Yas Yes 2□ No 25. Was case referred to medical axaminar? filled in by the funeral director, Be 26. Placa of Death (Check only ona) Hospital: Inpatiant Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 200 No 10 1 Yas 3□ DOA 2 ER/Outpatient After this 28a. Data of Injury (Month, Day Year) Certification: 27. Mannar of Death 28d. Describe how injury occurred or Attending Neturel 5 Pending Invastigation 1 TYas 2 No 2 Accidant 6 Could not be datarminad 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28e. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 4 Homicida Hospital 24 hours 12 Cartifying Physician: To tha bast of my knowledge, death occurred at tha tima, data and placa, and dua to tha ceusa(s) end menner as statad.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner statad. 29a. Cartifiar To the Hosp within 24 hou To the Fune completely fi edical (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of dectifie 29c. Licansa number D43453 April 30, 1999 Print) 30. Nama and addrass of pe d cause of Agnes BealthCare 900 Caton Avenue Baltimore, MD 21229

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Registrar

State

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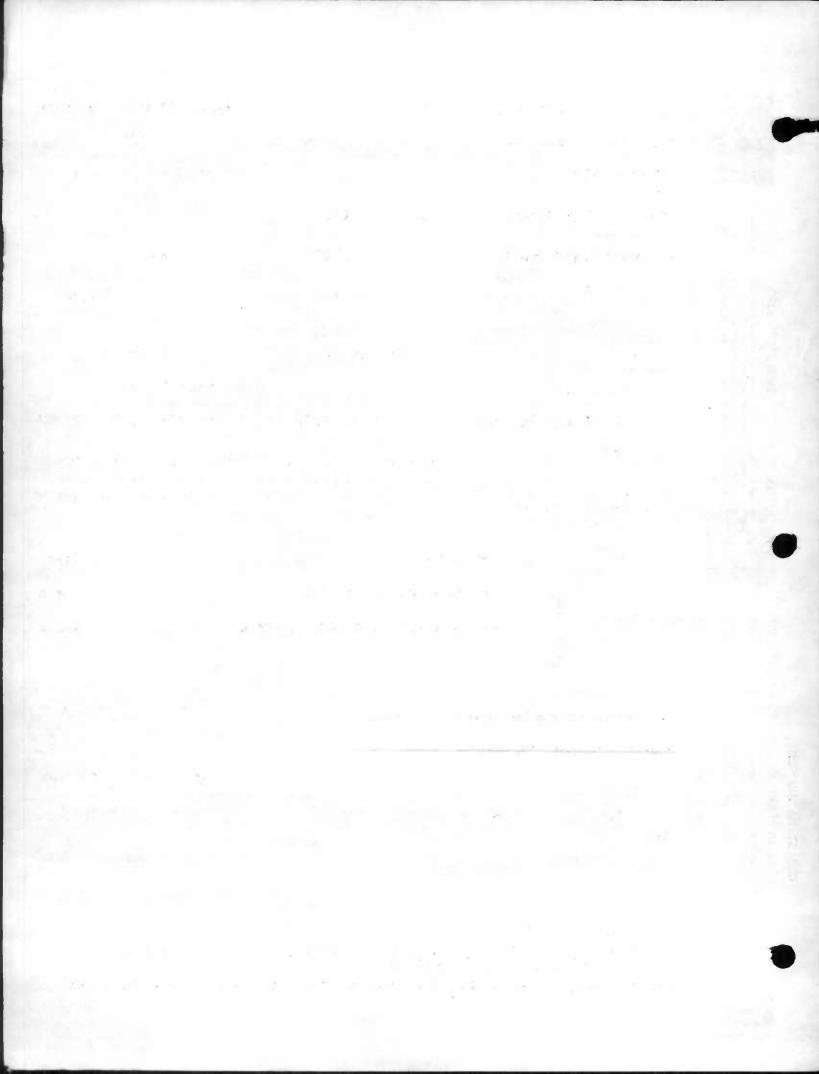
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31. Deta filed (Month, Dey, Year)

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rd Sidr	ney		State of M	aryland			Health and I If Death		giene		469				
	1. Decedent's Na	me (First, Middle, La:	st)					2. Date of De Month		V	3. Time of Death				
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Examiner	4a Facility Nama	(If not institution, give	a street and number)	March Location of Deat			10.50 20.1								
	9311 Rho	e Geo	rae's												
uneral	5. Social Security	Number 6. S		Park 8. Date of Bir (Month, Da	th y, Year)		place (State or Foreign intry)								
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natural, or items 23a or 28a-f show deal Examiner must be notified at sted by Funeral Director	Usual Residence	10b. County		10c. City, 1	Town or Locatio	n				10	d. Inside City Limits				
Examiner must be notified at by Funeral Director			0								t Yes 2 No				
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ă		node Islan	d Avenue			2074			USA	THAT COUNT	,				
Funeral	11. Marital Status		12. Was Decedent	Ever in U.S.	13 Was			inecify Yes or No		e - America	n Indian.				
F	The second second	rried 2 Married	1 TYas 2 TNo			Was Decedent of Hispanic Origin? (Specifi If Yes, specify Cuban, Mexican, Puerto Ric			ican, etc.) Black, W		Vhite, etc.				
by		4 □ Divorced	If Yes, Give Yeer or Detes:		101	res 201 N	lo Specify:		Specify	Whi	lte				
2		15. Decedent's Ed			16a. Decedent's	Usual Occ	cupation		16b. Kind of B	usiness/Indu	istry				
piel	(Specific Elementery/Sec	ecify only highest gra		completed) (Give kind of work of life. DO NOT use r				k done during most of working e retired)							
Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural any Injury or other traumatic event, the Health and Dags. To Be Completed	12	condaty (0-12)	Ø)	5+)	Mecha	nic			Tran	sporta	ation				
	17. Fathar's Nema	a (First, Middle, Last)					18. Mother's Nar	me (First, Middle							
	Leroy S	Sidney					Marie (Gray							
	19a. Informant's I	Name/Reletionship (Type, Print)		19b. Mailing Ad	idress (Stre	et and Number of Re	ural Route Numb	er, City or Town,	Stete, Zip (Code)				
	Dave Ca	udle/Neph	ew		2101	Lower	Marlboro	Road. O	wings.	Marvla	and 20736				
	20a. Method of Di	isposition			oe of Disposition	(Name of		Date	20c. Location						
		1 Burial 2 Cremation 3 Removed from State 4 Donetion 5 Other (Specify) Baltimore Washington Cr. 4/15/99 Laurel, Maryland													
		21. Signature of Funeral Service Licensee/ 22. Name and Address of Fecility													
		1	Deta Wi	\			Funeral Ho	ome, Inc	•						
	00 D W 5	7601 Sandy Spring Road, Laure1, Mary1and 207 23a. Pert1. Enturna disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hand failure. List only one cause on each line. Approximate Intarval Between													
	shock, or h	failure. List only	one cause on each li	o the death. ne.	Do not enter the	e mode of d	lying, such as cardia	c or respiratory e	rrest,		ntarval Between Onset and Death				
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r	Immediate Cause disease or conditi resulting in death	ion	a Cul	nios al	inte	and	somula	Dre	nl						
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Examiner			b							i					
xar	Sequentially list of if any, leading to	conditions, immediate		Due to (or e	s a consequenc	e of):									
Cal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury														
9	that inititeted events resulting in death) Last Due to (or as a consequence of):														
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etached for use as Physician/Me										I .					
hysic	Pert II. Other sign	ificant conditions of	ontributing to death b	ut not resulti	ng in the under	ying cause	given in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of death?				
								10	Yes 2□ No	3 Prob	bly 45 Unknow				
by P										T 045 14/-	- A #- P				
Completed									an autopsy	avai	e eutopsy findings labia prior to				
mpleted								lin	tel		pletion of causa sath?				
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Be	25. Was case refe examiner?	erred to medical					26. Piace of De	ath (Check only	one)	/					
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	27. Manner of Dea		28a. Date of Inju (Month, Da	ry Year) 20	3b. Time of Injury	28c. In	njury et Vork?	28d. Describe	how injury occur	red					
catic	2 Accident	5 Pending investigation	1	,,	N. Jon y		☐ Yes 2☐ No								
tille	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	200. Piece of inj	ury - At home	e, farm, street, f	actory, offic	> 0	28f. Location (City or To	Street and Numi	ber or Rural	Route Number,				
Certification:			Stricing, et	c. (Specify)				July 01 10	, 0.010)						
	29e. Certifier (Check only		ysician: To the best												
edical	one)	XX Medical Exam	niner: On the basis of and menner sto	examination eted.	and/or investig	ation, in my	y opinion, death occu	urred et the time,	date end piece,	and due to	me cause(s)				
Medical Certi	29b. Signature an	d titla of certifier	11			29c. Lice	ense number		29d. Data signe	d (Month, D	ay, Year)				

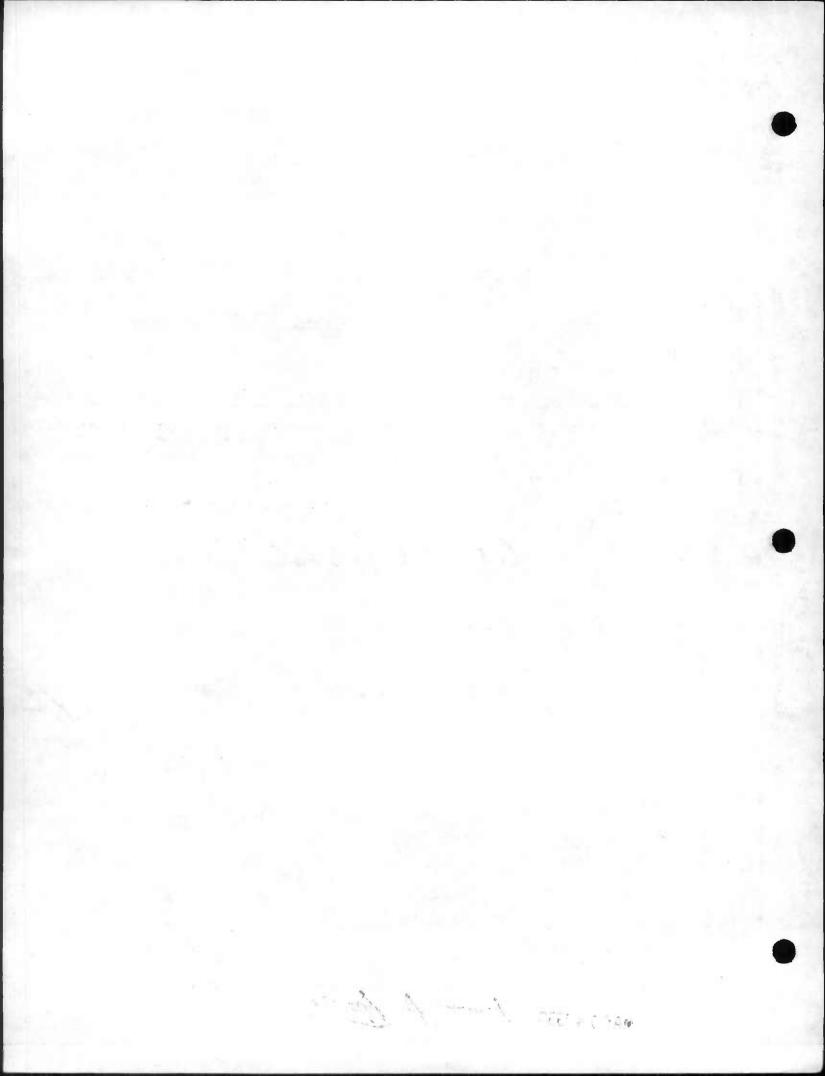
State Registrar

31. Date filed (Month, Day, Year)

nd eddress of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

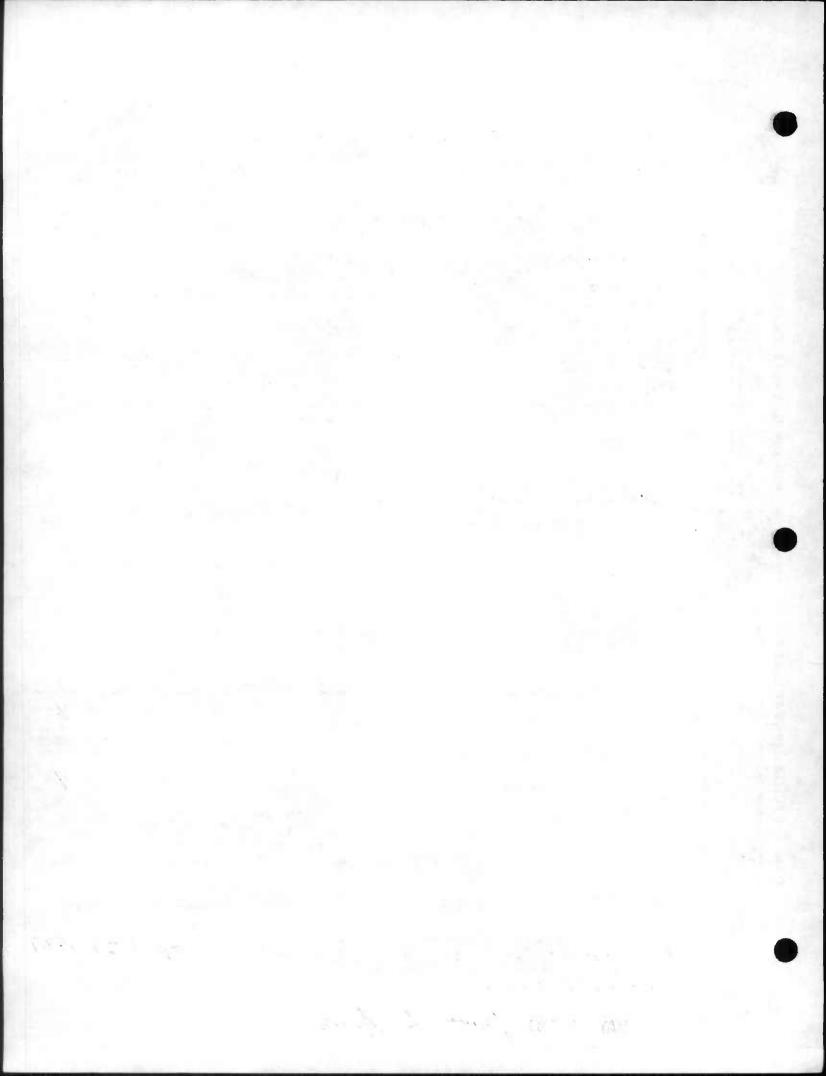
O.C.M.E.

April 01, 1999



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death April 28, 1999 **Physician** Wilson E. Smith 11:20pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Millennium Health & Rehab Center Edgewater Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | April 2, 1921 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1€M 2□ F 220-01-0284 78 Director Maryland Usual Residence of Decedant the Meryland 10b County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at 1 ☐ Yas 2 € No Director MD Anne Arundel Churchton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5617 Exeter Street USA Funeral 20733 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black White atc. filed within 72 hours efter Hygiena. 1 ☐ Yes ŽQNo If Yas, Giva 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 Yas 2 No Specify: à Yas, Give Yaar or Detas: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) permit. Peges 1 and 2 should be filed will Department of Health and Mental Hyglen, Important: If item 27 is marked other that any hojury or other traumatic avant, the pace. Railway Express 12 Manager/Dispatcher 18. Mother's Neme (First, Middle, Meiden Surnama) 17. Fathar's Nama (First, Middla, Last) Be James A. Smith Melvina 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Goldie A. Smith - Wife 5617 Exeter Street, Churchton, MD 20733 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematary, cremetory or other plece) Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata Metro Crematory 5/3 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore, MD 21. Signature of Jugeral Service Lig 22. Name and Addrass of Facility Hardesty Funeral Home, P.A. alluck 12 Ridgely Ave. Annapolis, MD 23a. Part1. Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final Zyears Sarcoma disaasa or condition resulting In death) Examiner Dua to (or as a consequence of) Examiner The law requires that the death certificate be assocuted physicien end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undartying Cause (Disaase or injury that initiated events rasulting In death) Last Dua to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. P.O. 1 Yes 2 No 3 Probably 4 Unknown signed t Records, by 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peeu pege 2 s 1 Yas 2 No certificate Division of Vital or Attending Physician: 25. Was casa rafarred to medical axaminar? Be 26. Place of Deeth (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Describe how injury occurred 27. Mannar of Deeth 28a. Data of Injury (Month, Day Year) 28b Tima of 28c. Injury at Work? Natural 5 Panding To the Hospital or Attanding within 24 hours after deeth. To the Funeral Diractor: Afte completely filled in by the fun 1□Yas 2□No 2 ☐ Accidant invastigation 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida 29a. Certifier edicai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and placa, and dua to the cause(s) and manner stated. (Check only one) 29b. Signeture and title 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and addrass of person who completed causa of death (Itam 23a) (Type, Print) Dr. Malta, 1833 A Forest Drive, Annapolis, MD 21401 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar 1999



				State of Marylan		artment of I rtificate of		lental Hy	giene		4471
۲	Physic	ian	Decedent's Name (First, Middle, La	(ist)	101	3TA 0		2. Data of De	eth Day	Year	3. Time of Death
	/Medi		MAZEL		1271	ETAR	, 1	April	29	Year 99	11:55 A.M.
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	pu		Usual Residence of Decedent 10e. State 10b. County	10c City	, Town or Lo	postion					
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	with the		10e. Street end Number			10f. Zip Code			10g. Citizen of	What Count	try?
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21215-0020	ithin 72 ho	Completed	15. Decedent's Et (Specify only highest gre Elementary/Secondary (0-12)	ducation ode completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usuel Occup kind of work done DO NOT use retire	petion during most of work! d)	ng	16b. Kind of B	usiness/Ind	ustry
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Z	should nd Mer merke	2	Jessie Gibson 19e. Informent's Name/Relationship (Type Print!	10h Mailir	na Addraes (Straat	Minnie Ba			Ctata Zin	Codel
or Hear of Hea		Marlia Singletary 20a. Method of Disposition 1□ Burial 2 © Cremation 3□	/ Daughter	11740 lece of Dispo		aurel Dri	ve, Lau Data	rel, Ma 20c. Location	rylan City or Tov	d 20708 wn, State	
Baltimore, permit. Peges 1 er Department of Hear Important: If Item; any Injury or other			4 □ Donation 5 □ Other (Specification of Funeral Service Licental Service	Derric	Baltimo k C. Jo ltimore	nee F	aryland uneral Hm. yland 21215				
)	Physician /Medical		23a. Part1. Enter the diseese, or compands, or heart failure. List only immediate Cause (Final	plications that could the death one couse on each ne.		er tha moda of dyi	ng, such as cerdiac o	r respiretory a	rrest,		Approximate Interval Between Onset and Deeth
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8760,	od / ou,	ai Examiner	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury	b. — Due to (or	as e conseq	uence of):					
Box 687 leeth certificate ettending physi	n/Medicai										
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s, P.O	se the se the bed	by Physician/M		oranio dang to dadar out not 1950	TOTAL PALL	23b. Did tobecco use contribute to the cause 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐					
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	lcian: Th certificate rector, per	Be	25. Was cese referred to medical examiner?	Hospital:		04	26. Place of Deeth				
o	Phys this rel di	. To	1 ☐ Yes 2 ☑ No 27. Menner of Death	1 □ Inpatient 2 □ E	Proutpation 28b. Time of		4 Mursing Hor		dence 6 Doth)
0	ling Afte fune	tion	1 Matural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Dey Year)	injury	28c. Injui Woo M 1 □	rk? Yes 2□No	LOG. Describe	iow injury occur	160	
Division of Vital	if or Attanding after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined		me, farm, str			28f. Location (City or Tox	Street and Numb vn, Stete)	er or Rural	Route Number,
	To the Hospital or I within 24 hours after To the Funeral Direct completely filled in the	edicai	29a. Certifiar (Check only one) 1 Certifying Phy	yeiclen: To the best of my know liner: On the basis of axaminati and menner stated.	rledge, deeth on and/or Inv	occurred at the tirestigation, in my o	me, date and place, e	and due to the ad et the time,	ceusa(s) end me date end place,	enner es ste and due to	eted. the ceuse(s)
	To the To the Comp	M	29b. Signatura and title of certifiar	there	M.	29c. Licans	2472 I		29d. Dete signe 4/30	d (Month, E	Pey, Year)
	4		30. Name and addrass of person who	completed ceuse of deeth (Item	23a) (Type, I	Print	Px 1	Aule	M	1	1710
	Sta	te	31. Date filad (Month, Dey, Year)	32. Registrar's Signate	ure /	13000112	-5, L	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	, ,,,	ی م	- 100

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Tatunczak Records, P.O. Box 68760 Steffanie

physician and the burial-transit á signed I page 2 Division of Vitai certificat this or Attanding death. Director: after within 24 hours aft To the Funeral Di completely filled in

Hospital

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Physician/M þ Completed Be

Physician

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Funeral

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23a or must be

'natural', or

filed within Hygiene.

Domit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiens. Important: if Item 27 is marked other than

Physician /Medical

Examine

Examine

rd

to

29, 1999

Baltimore, Maryland 2121

edical Certification: To

> State Registrar

DHMH 16 Rev 6/95

edicai

29e. Certifier

(Check only one)

29b. Signeture end titla of certifier

31. Date filed (Month, Day, Mear) MAY

anl

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

Tarig Mahmood, 32. Registrar's Signature

2300 Dulaney Valley Road, Timonium, MD 21093

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end manner as steted.

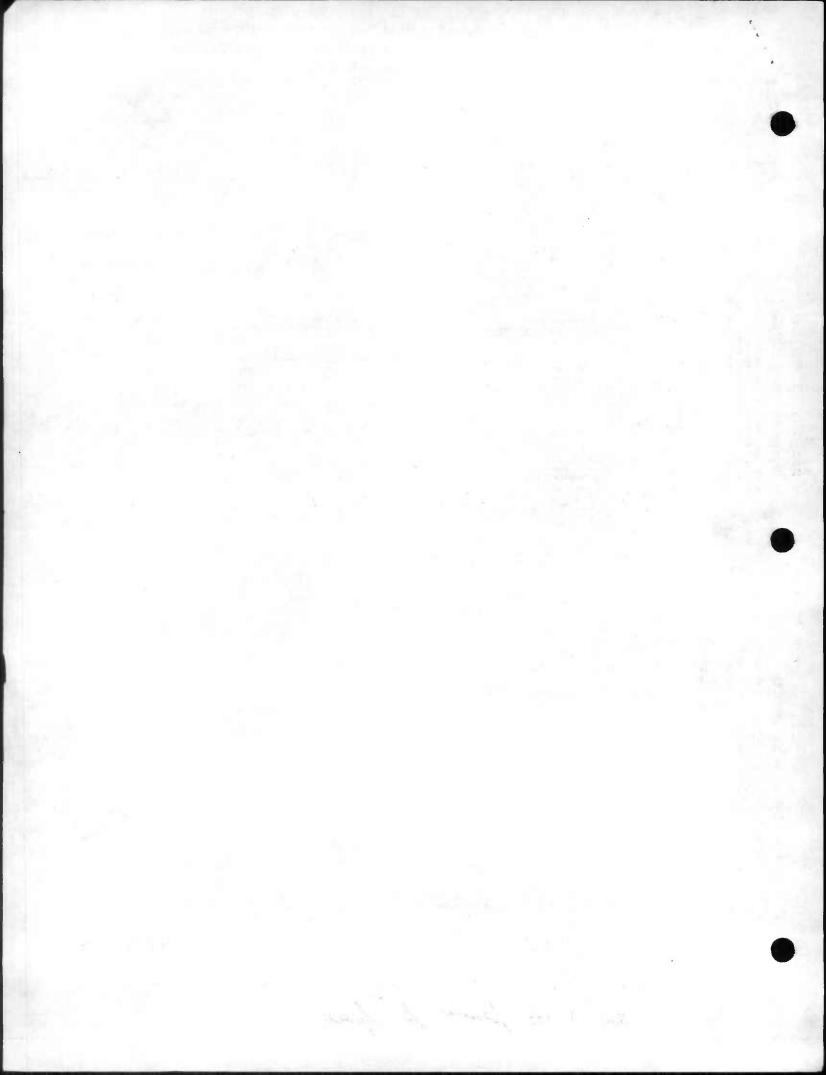
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

1)43725

29d. Date signed (Month, Day, Year)

30159



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Month **Physician** 05 01 1999 Raymond. unknown /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2010 BOONE STREET BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Months Days 1XM 20 F Hours 216-62-9532 Director 43 NOV 13 1955 MARYLAND Usual Rasidance of Decedant deeth with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flams 23s or 28s-f show the Medical Examiner must be notified at 1 Vas 2 No Director MARYLAND N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2010 BOONE STREET 21218 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11 Marital Status 14. Race - Amaricen Indian. permit. Peges 1 and 2 should be filed within 72 hours after of Department of Heelth and Mentel Hygiens. Important: if frem 27 is marked other than "natural", or then any injury or other traumatic event, the Hedges France. Black, Whita, atc. 1 X Yever Married 2 ☐ Married 1 ☐ Yas 2 XXIo Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) UNIVERSITY OF MD LABORATORY TECHNICIAN 8th grade 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be DOROTHY McCULLERS RAYMOND TURNER 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 1639 N SMALLWOOD ST, BALTIMORE, MARYLAND 21216 Candace Willis/Sister 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata t⊠Burial 2 ☐ Cramation 3 ☐ Removal from State 5-8-99 BALTIMORE, MARYLAND MT CALVARY CEMETERY 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensee 22. Nama end Addrass of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE Part1. Enter the disease, or complications that ceused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Batween Onset and Death **Physician** /Medical Immediala Causa (Final ears disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of) Examiner physician end the bunal-transit The law requires that the deeth certificate be executed Sequantially list conditions, if any, leading to immadiate causa. Entar Undarfying Ceusa (Diseasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Box 68760. Physician/Medicai Dua to (or as a consequence of): 980 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? should should 24a. Wes an autopsy performed? Completed page 2 s 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital or Attending Physician: funeral director Be 25. Was cesa referred to medicel 26. Place of Deeth (Check only one) Hospitel: Medicai Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tas 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Data of injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Matural 5 Panding invastigation deeth. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deet Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) à 4 Homicida filled in Hospital 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, daeth occurred at tha tima, date and place, end dua to the ceuse(s) and mannar as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. (Check only within 2 To the 29b. Signatura and title of certifian 29c. Licanse number 29d. Date signed (Month, Day, Year) ver 30

State Registrar

MAY 0 4 1998

DSILVER DO

31. Data filed (Month, Day, Year)

30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

341 64 N ST

32. Registrar's Signatura

6. April

Baltimore, Md 21224

MAY 01 1918 Sever b. Month

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\text{Q}\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** LIRBANCIK GEORGE 1130 HRS 1999 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE HOSPITAL SAMARITAN N/A If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. April 17, 1912 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 □ F 87 215-01-6640 Maryland Director Usuel Residence of Decedent the Maryland 10d. Inside City Limits 10e. Stete 10b. Count 10c. City. Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 □ No Directo Maryland N/A Baltimore 10g. Citizen of What Country? 10e Street and Number 10f Zin Code with 5311 Pembroke Avenue 21206 U.S.A. Funerai 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Marital Stetus 1 Never Married 2 Memled 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. Mail Supervisor Post Office 12th Grade permit. Pagas 1 and 2 should be file Department of Health and Mantal Hy Important: If Item 27 is marked othe eny Injury or other traumatic event. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Frank Urbancik Hrachovec Maru 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) George Urbancik, Jr. (son) 1312 Fordham Court, Bel Air, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 Buriel 2 □ Cremetion 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) Moreland Memorial Park 5/5/99 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Schimunek Funeral Home, Inc. 23a. Part 1. Enter the disease, of compilications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Robe 21236 Approximate Intervel Between Onset end Death **Physician** RESPIRATORY FAILURE /Medical Immediate Ceuse (Final disease or condition resulting in deeth) **Examiner** Due to (or es e consequence of):

CANCER Examiner ician and burial-transit requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Last Due to (or es e consequence of) physician s the burial Physician/Medicai Due to (or es e consequence of): signed by the at Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No UD IABETES þ 24b. Were eutopsy findings evailable prior to should 24e. Was en eutopsy Completed completion of cause of deeth? WE After this certificate has The 1 ☐ Yes 2 ☑ No 1 Yes 2 No Physicien: funeral director, 25. Wes cese referred to medical examiner? Be 28. Place of Deeth (Check only one) Hospital: 1 1 Inpatient 2 EN/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred of or Attending Farantees after death. 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 24 hours after de Funerel Directo letaly filled in by th 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide cai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Dete signed (Month, Dey, Yeer) 29c. License number 29b. Signature and title of oertifier 150047891 1999

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital

Registrar

31. Date filed (Month, Day, Year)

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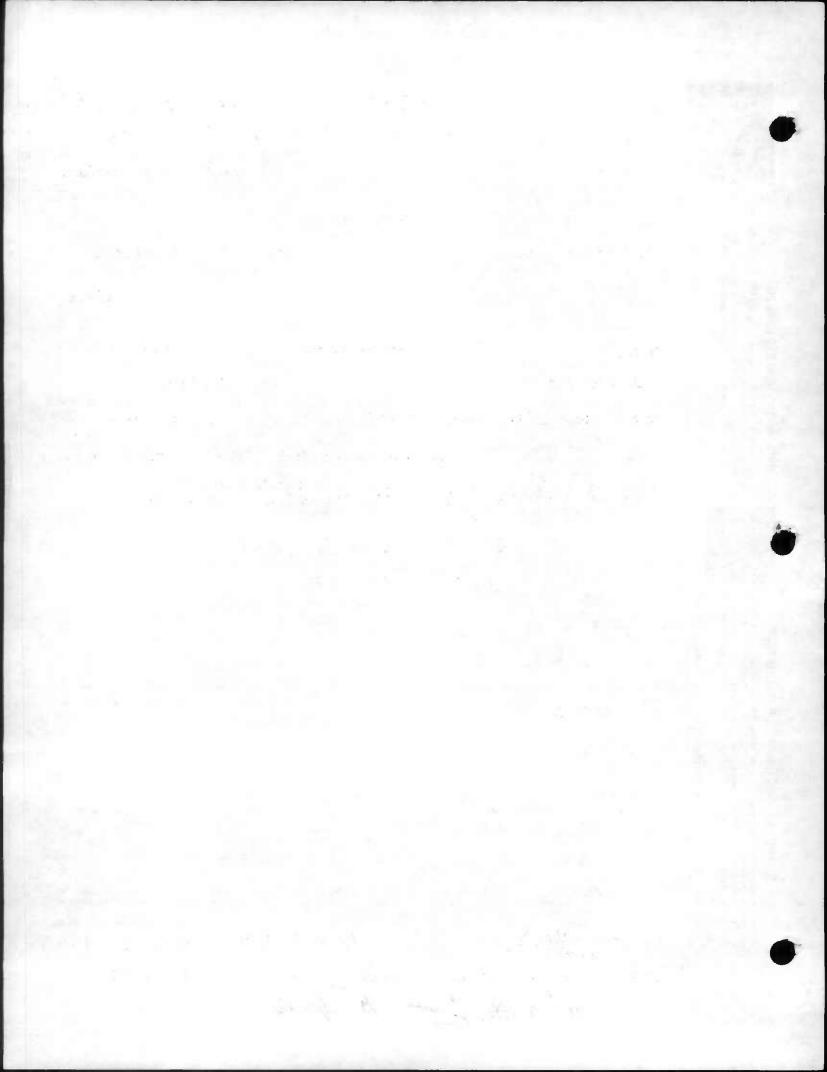
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30. Name end ecoress of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrer's signature

SAMARITAN GOVIS



CERTIFICATE #

14475

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CERTIFICATE M

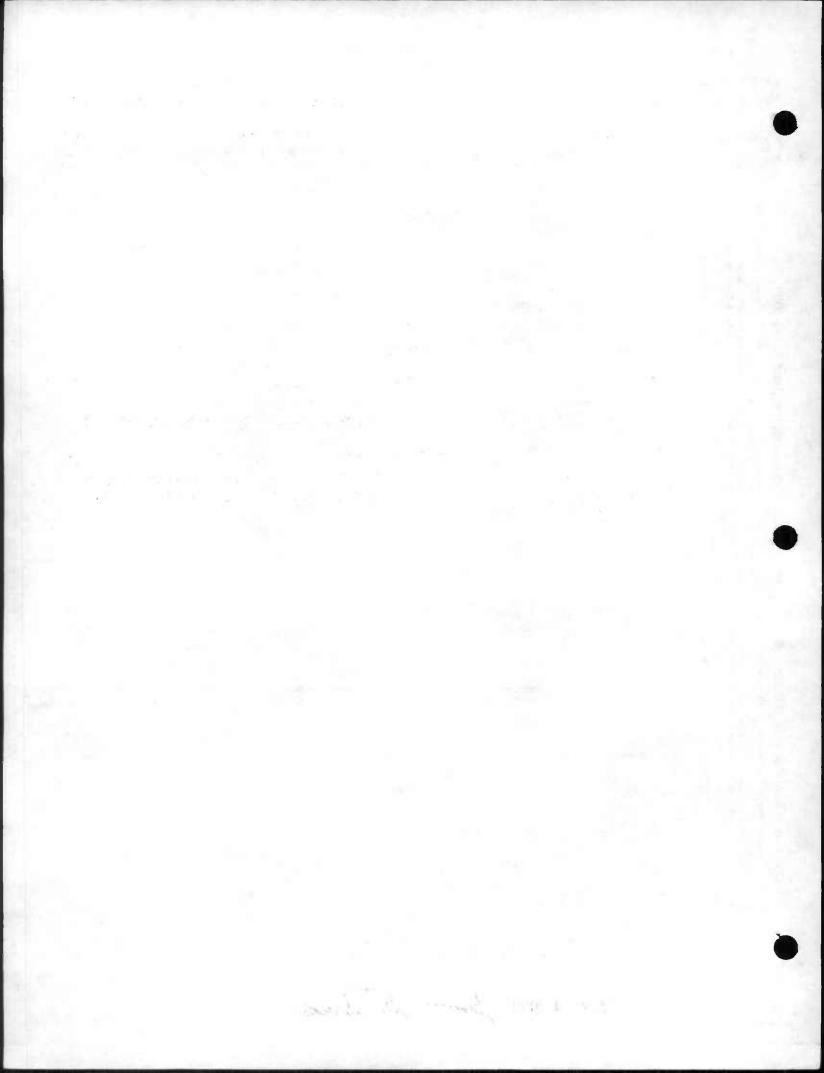




State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death APRIL 28, 1999 **Physician** SHIRLEY WINN 3:50 AM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 3041 FALLSTAFF ROAD #301D BALTIMORE N/A Birthplaca (Stete or Foreign Country) If Under 1 Year If Under 24 Hrs. Dete of Birth (Month, Day, Year) JUL. 24,1936 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Days Months Hours 1 M 2 XF 62 Yrs. 218-32-6450 MD Director Usuel Residenca of Decedent 10b. County 10c. City, Town or Location t Od. Inside City Limits 1 Yes 2 □ No Director MD BALTIMORE notifie 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code b 3041 FALLSTAFF ROAD #301D 21209 U.S.A. 238 Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Hems 11. Meritel Stetus filed within 72 hours after 1 Never Merried 2 Married 8 altimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No Specify: Specify: p 3 Widowed 4 XDivorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental MYER WINN ZELDA COHEN 2 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) vt: If Item 27 is n. v or other TERRI LORDEN / DAUGHTER 17 STRAWHILL COURT - OWINGS MILLS, MD 21117 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burlel 2 □ Cremetion 3 □ Removel from State BALTIMORE HEBREW CEMETERY 4/29/99 REISTERSTOWN, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 for s thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final ? 440 CALDIAL FARALEMON diseese or condition resulting in deeth) Examine Due to (or es e consequence of): Examiner burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest and Due to (or es e consequenca of): physician s the burial Box 68760. Physician/Medical Due to (or es e consequenca of): 95 USB signed by the at d be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings evellable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? ahould page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vitai or Attending Physician: director. 25. Wes case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 DNaturel 1 ☐ Yes 2 ☐ No 24 hours after death.
Funeral Director: A 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, term, street, tectory, office building, etc. (Specify) filled in by 4 | Homicide Hospital 1 Centrying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner es stated.
2 Kedical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the cause(s) and manner stated. edicai 29e. Certifier completely (Check only one) within 2 To the 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) acres ess of person who completed cause of deeth (Item 23e) (Type, Print) 30. Neme end end PIRODUCE MA-2120F" 16605-7168 31. Dete filed (Month, Day, Ye 1999 Register's Signeture

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** ELIZA BETH WRIGHT 6:15 AM MAY 1999 - /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Johns Hopkins Bayview Geratrics Baltimore N/A if Under 1 Year if Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Days 1 ☐ M 2 🗓 F Months Hours Maryland Director 82 218-42-1921 Dec. 20, 1916 Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10e State 10b County 10c City Town or Location 7 is marked other than "natural", or items 23a or 28a-f shov traumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Baltimore Maryland Director Dundalk 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of Whet Country? 35 Mavista Avenue 21222 United States death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 14. Race - American Indien. 11. Marital Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Departmant of Health end Mental Hygiena. If them 27 Is marked other than "natural", or the 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 3 years Home Maker Own_Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) William R. Walton Augusta Louise Allgier 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) John Wright (Son) 2712 Creston Road Baltimore, Maryland 21222 other t Baltimore, 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) any Injury or o Oak Lawn Cemetery 5/5/99 Baltimore, Maryland 22. Name end Address of Fecility Puda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Avenue Dundalk, Maryland 21222
Shock, or heert feilure. List only one ceuse on each line.

Approximately the death of the death of the mode of dying, such as cardiac or respiratory errest, **Physician** /Medical Immediate Ceuse (Final SQUAMOUS CELL CANCER, (R) LUNG disease or condition resulting in death) Examiner Examiner Cerebro vascular accidence certificate be axecuted ician and burial-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Last c. COPD Kars Box 68760. attending physician Physician/Medicai the t Due to (or es e consequenca of): use as t Po Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 9 preumoperibreum 2º PEG placement 1 Yss 2 No 3 Probably 4 Unknown ò Division of Vital Records, 8 fascial wound dehiscence 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Wes en eutopsy dentlater dependant 1 ☐ Yes 2 ☐ No 1 Tes 2 □ Ne 25. Wes case referred to medical examiner? or Attending Physician: funeral director, Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1☐Inpatient 2☐ER/Outpatient 3☐ DOA Certification: To this 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of After 1 Neturel 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: Af investigation 2 Accident 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 ☐ Homleide Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

| Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end menner stated. 29a. Certifier Medical (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and tale of continer MD 99 D50648 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Hopkins-Bayview Cr

32. Registrar's Signeture

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DHMH 16 Rev 6/95

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31. Dete filed (Month, Day, Year)

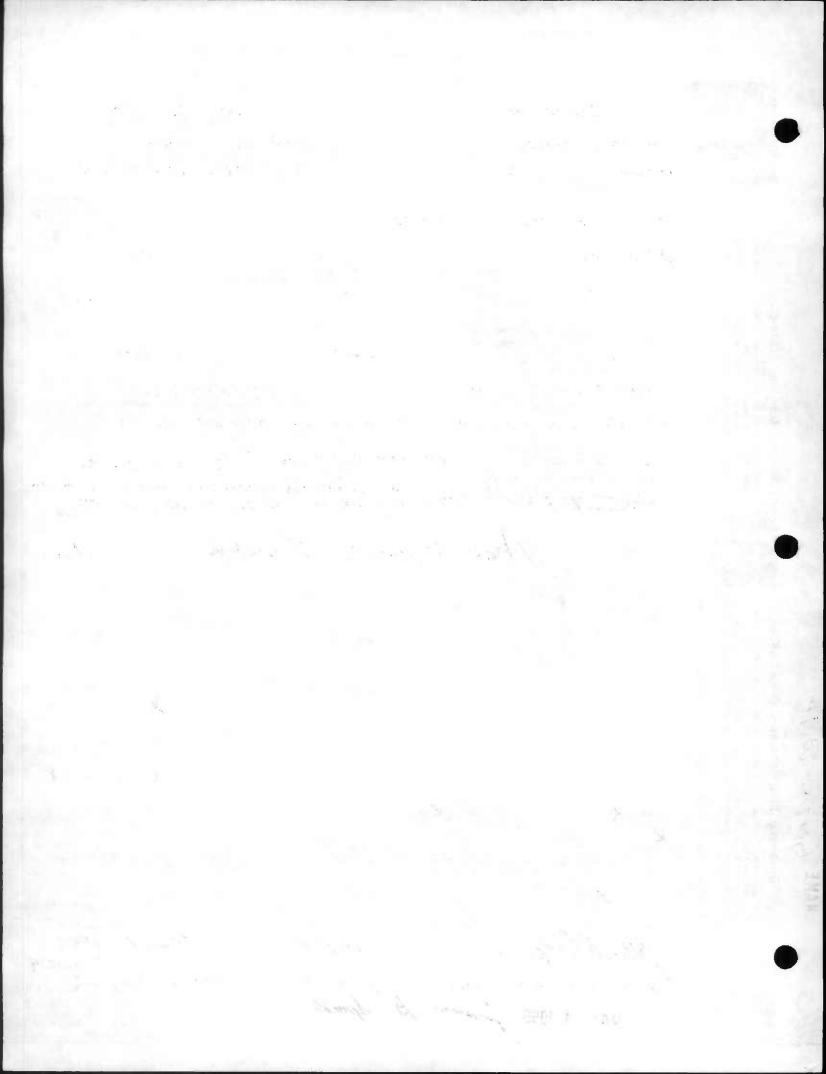
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1999

Donald

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** Gertie Elizabeth Wilt 02 MAY 1999 06:51A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner St. Agnes Hospital Baltimore N/A Birthplaca (Steta or Foraign Country) If Undar 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Ye 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Months Hours 1□ M 2□ F 215-28-9134 69 Yrs JUNE 6, Virginia Director Usual Residence of Decedan the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f ahow 1 Yas 2 No Directo Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? me 23a or 14 Third Avenue 21227 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexicen, Puerto Rican, etc.) 7 is marked other than "natural", or items traumatic avent, the Medical Examiner ma 14. Race - Amaricen Indien, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. nnt: if Itam 27 is marked other than "natural", or ite 1 Yas 2 No 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify. white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 Housewife Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surnama) Be (Unobtainable) Sprouse Virginia Buckingham 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21227 Cecil C. Wilt, Sr. - husband 14 Third Avenue, Halethorpe, Md. 20b. Place of Disposition (Name of cemetary, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 KBurial 2 Cremetion 3 Removal from Stata 5/6/99 = ō permit. Pege Department of Important: If any Injury or once. Meadowridge Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Elkridge. Md. 22. Name and Addrass of Facility 21. Signature of Funeral Sarvice Loss and Gary L. Kaufman Funeral Home@ Meadowridge MP, Inc. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21075 Approximata Intervel Batween Onsat and Death **Physician** Myocardial Infurction Immediate Cause (Final diseesa or condition rasulting in daath) /Medical hour Examine Due to (or as a consequence of) Examiner physicien end s the buriel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Causa (Disease or injury that initieted avents resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequance of): Part II. Other stanificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 TYes by 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? s certificate has b NAME Gertie Hospital or Attanding Physician: 25. Was cese referred to medical examiner? 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Mangar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 Panding 1 Yes 2 No investigation 6 Could not be datermined 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Straet end Number or Rural Route Number, City or Town, Stata) Direc 4 Homicida 24 hours Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and menner stated. 29a. Cartifier edical To the Hosp within 24 ho To the Fune completely f (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number and address of person who completed cause of death (Itam 23a) (Type, Print) 900 Caton Avenue Baltimore Many Scanbles nus 32. Rapistrar's Signatura Registrar



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72 hours after

filled within

lew requires that the death cartificate be axecuted

The

Physician:

Division of Vital Records, P.O. Box 68760

State Registrar 31. Date filed (Month, Day, Year) MAI 04

29b. Signatura and titla of certifian

C. RAVIMP NHC, 32. Registrar's Signatura

30. Name and address of person who complated ceusa of daath (Itam 23a) (Type, Print)

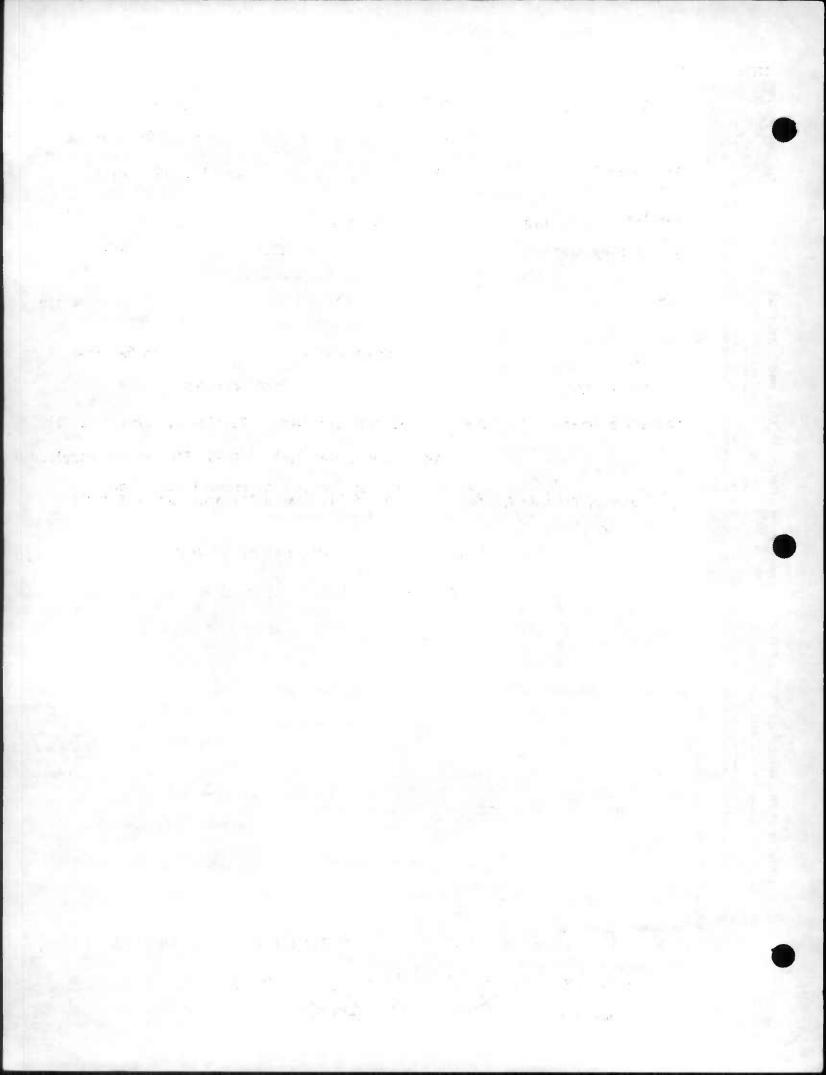
BALTO. MO 21133

2 Medical Examinar: On the basis of examination and/or investigation, In my opinion, death occurred et the time, data and place, and due to the cause(s) and manner stated.

29c. Licanse number

37333

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Data of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) CHARLES 00 H YEAGER MAY 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death BALTIMORE NIA EVER GREEN AUE 700 If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar Social Sacurity Number 8. Sax 7. Aga (In yrs. last birthday) Birthplaca (State or Foraign Country) 18 M 20 F Months Days 85 Yrs. 218-10-4478 MARCH 24, 1912 Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No MD BALTIMORE NIA 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 11.5.A 2700 AUE 21214 EVERGREEN 14. Race - American Indian, 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 11. Marital Status Black, Whita, atc. I □ Yas 2₽ No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married 1 Yas 2 No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) 12th EXPEDITONER GLEN. L. MARTIN. CO. NIA 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) UNKNOWN HENRY YEAGER 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) HELEN. V. YEAGER AUE. BALTO MD WIFE 2700 EVERGREEN 21214 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Locetion - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) GreenMOUNT CREMATORY 5/4/99 BALTO. 21. Signature of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility HARTLEY Miller Funeral Home Miller HAFFORD RD. BALTO. MD 21234 7527 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata fnterval Batween Onsat and Death ACUTE CONGESTIVE HEART FAILURE Immediata Causa (Final disease or condition rasulting in daath) ATHEROSCIEROTIC CARDIOVASCULAR DISTASE Dua to (or as a consequence of): CHRONIC REMAL FAILURE 23b. Dfd tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Physician /Medical **Examiner**

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To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by

or Attending

Completed

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29b. Signature and titla of contifiar

31. Data filed (Month, Day, Yaar)

Wellemon, 4.D

32. Registrar' Signature

30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

NETOR M. CARMONA, M.D.

MAY

Box 68760. the deeth certificate be

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itema 23a or 28a-f ahov the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer. Department of Heelth end Mental Hygiene. Important: If Item 27 is marked other than "natural", or item eny injury or other treumatic event, the Medical Examinat

Saltimore, Maryland 21215-0020

Director

Funeral

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Examiner Sequantially list conditions, if any, leading to immadiate causa. Enter Underlying Causa (Diseasa or Injury that initiated avants rasulting in death) Last Physician/Medical by

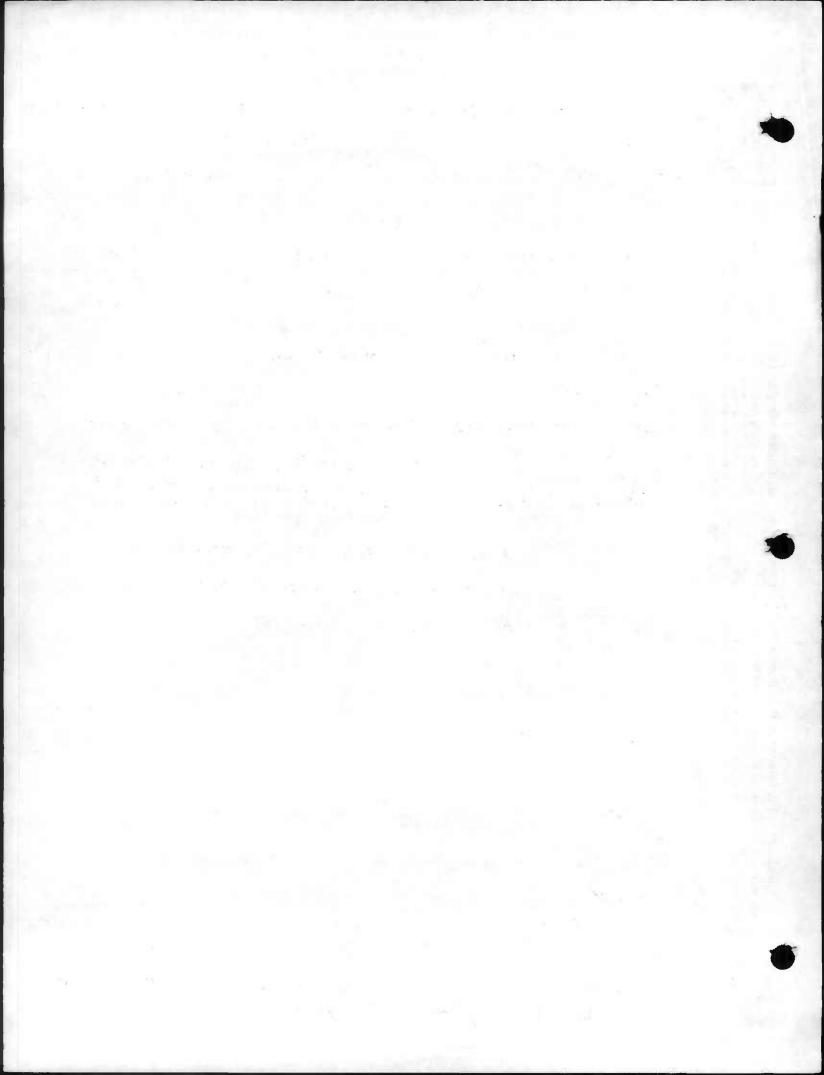
1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to 24a. Was an autopsy performed? complation of ceuse of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was cese rafarred to medical examinar? 26. Place of Daath (Chack only ona) Hospital: Othar: 4 □ Nursing Homa 5 Kasidance 6 □ Othar (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 1 Matural 5 Pendina 1 ☐ Yas 2 ☐ No invastigation 2 ☐ Accidant 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homlcida 29a. Cartifier 1 [Decertifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and due to tha causa(s) and mannar as stated. (Chack only 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29c. Licansa number

6012 HARFORD Rd., BAUTINOPE, Ind. 21214

29d. Data signad (Month, Day, Year)

State Registrar



72 hours efter death with the Maryland

filed within

Hygiene.

Pages 1 and 2 should be a

nt of Health e if item 27 is or other tre

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month DAVID ADAMSON 1999 April 17 4:35a 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death The Memorial hospital Talbot Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 25, 1 5. Social Security Number 7. Age (In vrs. lest birthday) 9. Birthplaca (State or Foreign 1√2 M 2□ F Months ! Days Hours Min 329-09-7702 Yrs. SCOTLAND Usual Residence of Decedent 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ONE DOWNING STREET 21601 USA 12. Was Decedent Ever in U,S.
Armed Forces?

1 ★ Armed Forces Armed F Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14 Race - American Indian 11. Marital Status Black, Whita, etc. 1 Nevar Married 20 Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 LITHOGRAPHER PRINTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) WILLIAM S. ADAMSON JANE FISHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIVIAN W. ADAMSON / WIFE ONE DOWNING STREET, EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Locetion - City or Town, State WBurial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY 4-24-99 DANVILLE, ILLINOIS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBIEN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601

23a. Part1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final coll carcenone mitt disaase or condition resulting in death) card Sequantially list conditions, if any, laading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 ☐ Unknown 1 Yes 2 No 24a. Was an autopsy performed?

Physician /Medical Examiner

that the death certificate be executed

or Attending Physician:

Hospital

Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

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7 is marked other than "natural", or items 23s or traumatic event, tre Medical Examiner must be a

Director

Funeral

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Examiner physician s the buriel Physician/Medicai 98 -Se signed by the e 2 Completed Be

irector, pege 2 s director. Certification: To this After after deet Director:

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 25. Was cese returned to medical 26. Place of Death (Check only one) 2 100 1 Yes/ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation

24b. Were eutopsy findings available prior to completion of ceuse of death? 2 No 1 ☐ Yes 1 TYPS 2 DAG Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifler (Check only one)

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

1 Yas 2 No

29b. Signature and the of certified

6 Could not be

APR 1 9 1999

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

219 S. WASHINGTON ST., EASTON, MD 21601 HUNG T. DAVIS, M.D., 31. Date filed (Month, Day, Yeer)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar 32. Registrar's Signature

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Certificate of Death	Reg. No.	,			
of Maryland / Department of Health and Mei	ntal Hygiene		44	8	2

				Certificate of	Death		Re	g. No.	,	, ,			
	1. Decedent's Name (First, Mid	dle, Last)				2.	Date of Death Month	Day	Year	3. Time of Death			
Physician /Medical	MIRIAM	Ρ.		ALBAUG	H	P	PRIL		1999	1:40pm			
Examiner	4a Fecility Name (If not instituti	on, give street and numb	er)		4b. City, To	own, or Locat	ion of Death	4c. County	of Deeth				
	WILLIAM HILL					EASTO		TAL					
Funeral Director	5. Social Security Number 214-74-3281 Usuel Residence of Decedent	1□M 21XE	Age (In yrs. last bir 94	Yrs. If Under 1 Yea Months Deys		Min.	Date of Birth (Month, Day, IAY 20,		Count	ace (State or Foreign ry) LAND			
show ad at	10a. State 10b. Coun	y	10c. City, Tow	n or Location					10	d. Inside City Limits			
vith the Mary or 28s-1 sh be notified Director	MD	TALBOT		EASTON 10f. Zip Code			10	g. Citizen of V	What Count	1 X Yes 2 No			
23a or 2	10e. Street end Number 29 BRITTANY T	'ERRACE		2	1601			USA					
21215-0020 d within 72 hours effer death with the Maryland jiene. Than "natural", or form 23a or 28a-f show the Modical Examiner must be notified at completed by Funeral Director	11. Maritel Status 1 ☐ Never Married 2 ☐ Ma 3 ☒ Widowed 4 ☐ Divorce	If Yes, Give	es? MNo	13. Wes Decedent of If Yes, specify Cu 1 ☐ Yes 2 🔯 No			y Yes or No- an, etc.)		e - America ck, White, e : WHI	otc.			
1 21215-0 ed within 72 ho ygiene. nor than "naturi rt, the Medical Completed		ent's Education est grade completed)	16a.	Decedent's Usual Occi (Give kind of work don life. DO NOT use retir	upation e <i>during</i> mos	st of working	1	6b. Kind of Bu	usiness/Ind	ustry			
T = 19 5	Elementary/Secondary (0-12)	College (1-4	or 5+)		ed)			OUDI	HOME				
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S See W		ORTER				RGINI							
Maryla d 2 should th end Mer 7 is marke traumatic	19a. Informant's Name/Relation	nship (Type, Print)	195	. Mailing Address (Street	et end Numb	er or Rural F	loute Number,	City or Town,	State, Zip	Code)			
≥ p=22=	GEORGE THOMSEN	/ EST. PER	REP.	L N. CHARLES	ST.,	STE.	400, BA						
\$ 50 50	20a. Method of Disposition	3 Removal from Sta	cemete	f Disposition (Name of ry, crematory or other p				Oc. Location -	,				
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Baltimore, permit. Peges 1 at Department of Hea Important: If Item: any injury or othe	21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOM 200 S. HARRISON ST., EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,												
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/Medical Examiner	Immediate Ceuse (Final disease or condition	heu	te Ma	D Cordiel	dn	day	tem		i	Minutes			
()	resulting in death)	1/	Due to (or es a	consequence of	4.60.	1	Oures.			Minutes			
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O, exact of the second of the	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury												
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Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Oirector: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier 112 Certify (Check only one) 2 Medica	ring Physician: To the be at Examiner: On the basi end menne	s of examination ar	e, death occurred at the nd/or investigation, in my	time, date a opinion, de	nd place, and ath occurred	d due to the ca at the time, da	use(s) and mate and place,	anner es si and due to	ated. the ceuse(s)			
To the comp	29b. Signature and title of certif	m HWao	00	MD 29c. Lice	nse number	7	25	9d. Date signe	d (Month,	Day, Year)			
	30. Neme and address of person	n who completed cause	of death (Item 23a)	(Type, Print)				- 1	/				
	WILLIAM H. WO	OOD, JR., M.	D., 506	IDLEWILD AV	ENUE,	EASTO	N, MD 2	21601					
State	31. Dete filed (Month, Day, Yea	1r) 32. Reg	pistrar's Signature	, ,									
Registrar	APR 2	0 1999	Jeneva	D. Apa	eks								

State of Maryland / Department of Health and Mental Hygiene

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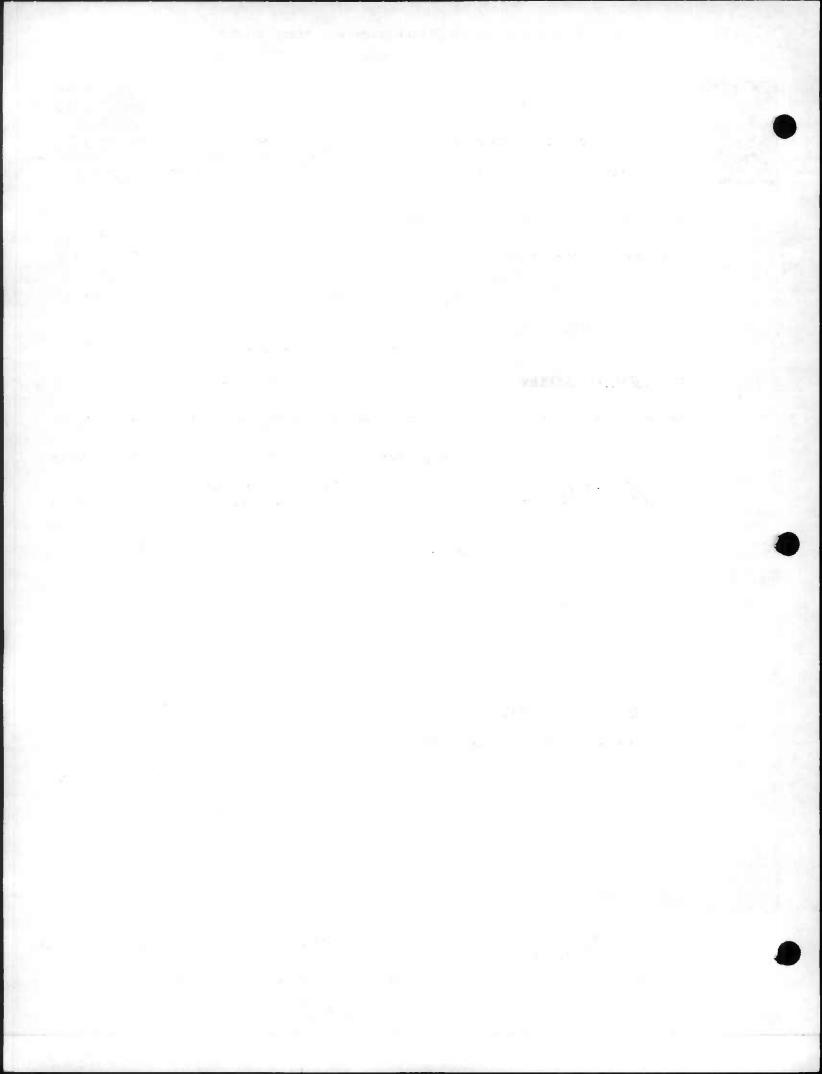
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day 1999 Yeer **Physician** April 22, 1:05 PM George Calvert Adkins /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 5317 Beaver Neck Village Road Linkwood Dorchester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Feb 1, 1933 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** X□M 2□F 220-28-1193 Yrs. Director Maryland Usuel Residence of Decadent 10e State 10b County 10c. City, Town or Location 10d. Inside City Limits Be Completed by Funeral Director 1 Yes 2 No Marvland Dorchester Linkwood 10e. Street end Number 10f Zin Code 10g. Citizen of Whet Country? 5317 Beaver Neck Village Road 21835 US 12. Wes Decadent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 1 X Xes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🕅 No Specify: 54 56 White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Food Processing Maintenance Worker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Pages 1 and 2 should be far ment of Health and Mental H ant: If Item 27 is merhed oth jury or other traumatic even Charles Calvin Adkins Mary Harper 19e. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dorothy Lee Adkins Wife 5317 Beaver Neck Village RD Linkwood, MD 21835 20e. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete XX Buriel 2 Cremetion 3 Removel from State Department of Important: If any injury or Dorchester Memorial Park 4/25/99 Cambridge, Maryland 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Acansee 22. Name end Address of Facility
Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a. Pertf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical Sepsis 10 0045 Examiner Due to (or es e consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the bunal-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, physician Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown þ Chronic Reval failure 24b. Were eutopsy findings evailable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? 2 KI No this certificate Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ◯ No 24 hours after death.

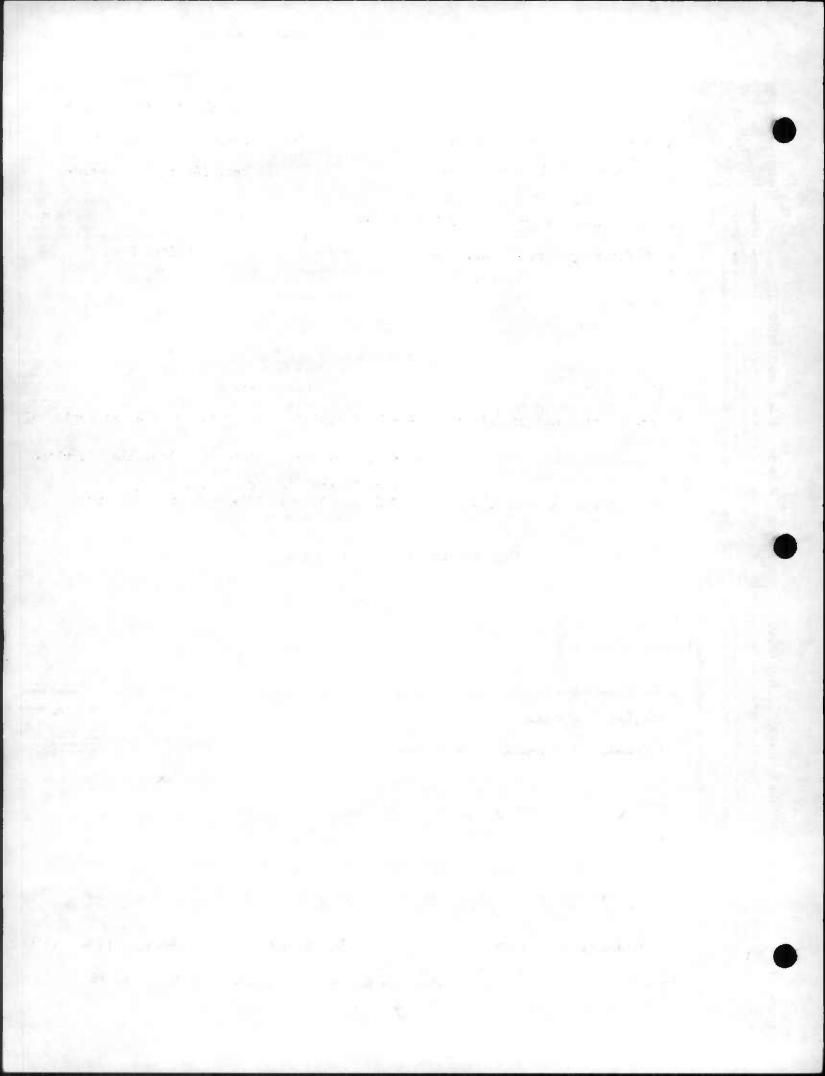
Funeral Director: After this letely filled in by the funeral 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Medicai Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 15x Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end placa, end due to the cause(s) end menner es steted.

2 Medical Exeminer: On the besis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner steted. 29a. Certifier within 24 hor To the Fune completely fi the 29b. Signelure end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) D 47924 4-23-99 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CAMBRIDGE NOD 10 AURORA NOMAN THANWY 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State APR 2 6 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene 0 1 1 1 8 5

hysician	1. D	ecedent's Nama	(First, Middl	la, Last)				tificate o		2. Deta of Dec			3. Time of Death	
		Co1	1on	Burke						April	18, 1999	Yaar 9	1:35 AM	
/Medical	40 [ecility Nema (If			end number	•)			4b. City, Town, or I					
xaminer	100	Vashingt							Takoma Pa	ark	Montgo	omery		
		ocial Sacurity Nu		6. Sex			est birthday)	If Undar 1 Ya	ar If Under 24 Hrs.		th .	9. Birthplace	a (Stata or Foreig	
ineral rector	21	5-20-36 al Rasidence of	87	1 🕅 M	2□ F	71	Yrs.	Months Day	s Hours Min.	8. Date of Bird (Month, Da Dec. 26	1927	Tenne	ssee	
show det	10a.	Stata	10b. County				, Town or Lo						Insida City Limits	
Important: If then 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumetic event, the Modical Examiner must be notified at once. To Be Completed by Funeral Director	Ma	aryland		gomery		511	ver Sp				10- Chinas of M	Citizen of What Country?		
	100.	Streef end Num 0120 New		shire	Avenue	, #10	3	10f. Zip Code 20903			United S			
	11.1	Marifel Status	ed 2 Mar	12. W	as Decedan med Forces ☐ Yas 2 ☑ Yas, Give eer or Datas	f Ever in U, ? No	S. 13. V	Vas Decedant of Yes, specify C	f Hispanic Orlgin? (S uban, Maxican, Puart lo Specify:	pecify Yas or No o Rican, etc.)	14. Reca Blac Specify	k, White, atc		
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	E	lementery/Secon			ollega (1-4o	Unemployed					N/A			
	17. 8	17. Fethar's Nama <i>(First, Middl</i> a, <i>Last)</i> Richard Burke							18. Mothar's Nan Della G		, Maidan Sumem	Θ)		
To To	Richard Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Streat and Number or Rural Routa Number, City or Town, Ste										Stete. Zip Co	oda) 2177(
Department of health and Important: If item 27 is in large and injury or other traum ance.		ebroah S				ece)			Clain Roa					
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	-	Signatura of Fur					Ra Ra	Nama and Adapp Fune	drass of Fecility eral Servi			- 000	110	
		La	20	UX	lex	~-			Avenue, S dying, such es cardiae				Pproximata	
i physician end is the buriel-trensit edical Examiner		uantially list cor ny, laading to im se. Enter Unda ise (Diseasa or i initiated avants ulting in deeth) L		b			r es e conseq r es e conseq							
sich sich	Part	II. Other signifi				but not ras	ulting In tha u	ndarlying causa	given in Part I.	23b. Dld	tobacco use co	ntribute to th	ne cause of death	
y Phy		Possible Laryngeal carrinoma								10	1 Yes 2 No 3 Probably		bly 4 Unkno	
s been signed to should be det pleted by P									24e. W.		Vas an autopsy erformed?		autopsy findings able prior to plation of cause ath?	
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rifficate has been signed by the ettending ctor, page 2 should be deteched for use e	25.	Was casa rafarr	red to medica	al					26. Placa of De	ath (Chack only	ona)			
is certificate has been sign i director, page 2 should be To Be Completed by	25.	Was casa rafari examinar? 1 □ Yas 2 🛣		al Hospi	tal: 1 🖄 Inpa	tiant 2	ER/Outpatier	nt 3 DOA	Other		ona) idanca 6 □Oth	ar (Specify)		
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this certifical director	25. 27.	examinar? 1	5 Pandi invast 6 Could detarr	Hosping 21 ing ligation nof be minad 21 ing Physicial Examiner:	Be. Place of Inbuilding, To the beston the basis	njury Pay Year) njury - At heatc. (Spacified of my known of axamina	28b. Tima o injury	f 28c. In M 28c. In M 28c. In occurred et the vestigation, in m	Other: 4 Nursing Injury at Nork? Very Yes 2 No	doma 5 Ras 28d. Describe 28f. Location City or To	idanca 6 Oth how injury occur (Streat and Numburn, Stata) cause(s) end mu, date and placa,	per or Rural F anner es stet end due to the	ed. ha cause(s)	
Ne Funeral Director: After this certification by the funeral director edical Certification: To Be	25. 27.	examinar? 1 Yas 2	5 Pandi invast 6 Could detarr	Hosping 2i gation I nof be minad 2i garannad 2i Examiner:	Be. Place of Inbuilding, To the beston the basis	njury Pay Year) njury - At heatc. (Spacified of my known of axamina	28b. Tima o injury	28c. I M 28c. I M raet, factory, offi n occurred at the vestigation, in m 29c. Lic	Other: 4 Nursing I	doma 5 Ras 28d. Describe 28f. Location City or To	idanca 6 Oth how injury occur (Streat and Numburn, Stata) cause(s) end mu, date and placa,	per or Rural F anner es stet end due to the	ed. ha cause(s)	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician	
/Medical	
Examiner	

Funeral

Director

If item 27 is marked other than "netural", or items 23s or 28s-f show or other treumstic event, the Madical Examinat must be notified at permit. Pages 1 and 2 should be filed within Department of Health end Mental Hygiene. Important: If tem 27 is merked other than any Injury or other treumatic avant.

Frodersen

Edward

Physician /Medical Examiner

buriel-transit and physician a signed by I cartificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica complatally filled in by the funeral director.

P.O. Box 68760,

Records,

Division of Vital

1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Yeer CHARLES EDWARD BRODERSEN 19, 1999 April 8:36pm 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Community Hospital Lanham Prince George's Co. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Days Hours Yrs. Oklahoma 577-60-0476 Usuel Residence of Decedent 1906 10e State 10c. City, Town or Location 10d. Inside City Limits Prince Georges 1 Yes 2 No Director Maryland Lanham County 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20706-1104 7210 Kempton Road USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ☑No If Yes, Give Yeer or Dates: 11. Maritei Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: by 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 5+ Lawyer-Dept of Agriculture US Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Jennie Sabrina Hansen Henry Edward Brodersen 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clark Brodersen (Son) 3106 North 17th Street-Arlington, Va. 22201 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Gardens Cem. - Apr. 23, 199 Arlington, Virginia 21. Signature of Buneral Service Licensee 22. Name end Address of Facility Arlington Funeral Home-Arlington, Va. 22203 3901 North Fairfax Drive is, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediete Ceuse (Final 1 bours Due to (or es e conséquence of): disease or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting In death) Lest M98208ELBROTIC HYDORTEN SWE Physician/Medical Due to (or es e consequence of): Chen Witterung Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 25 No 3 Probably 4 Unknown CEREBRA þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Wes cese referred to medical Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Nes 2 No 1 Inpatient 2 DEN/Outpetient 3 DOA 28c. Injury et Work? 27. Manner of Deeth 28e. Date of Injury (Month, Dev Year) 28d. Describe how injury occurred Certification: 28b. Time of 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide 1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) a hory 116197 30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

MO: 9326 LANGER - SERERY

32. Régistrer's Signature

RO. LANKEM.

State Registrar

C. LARA.

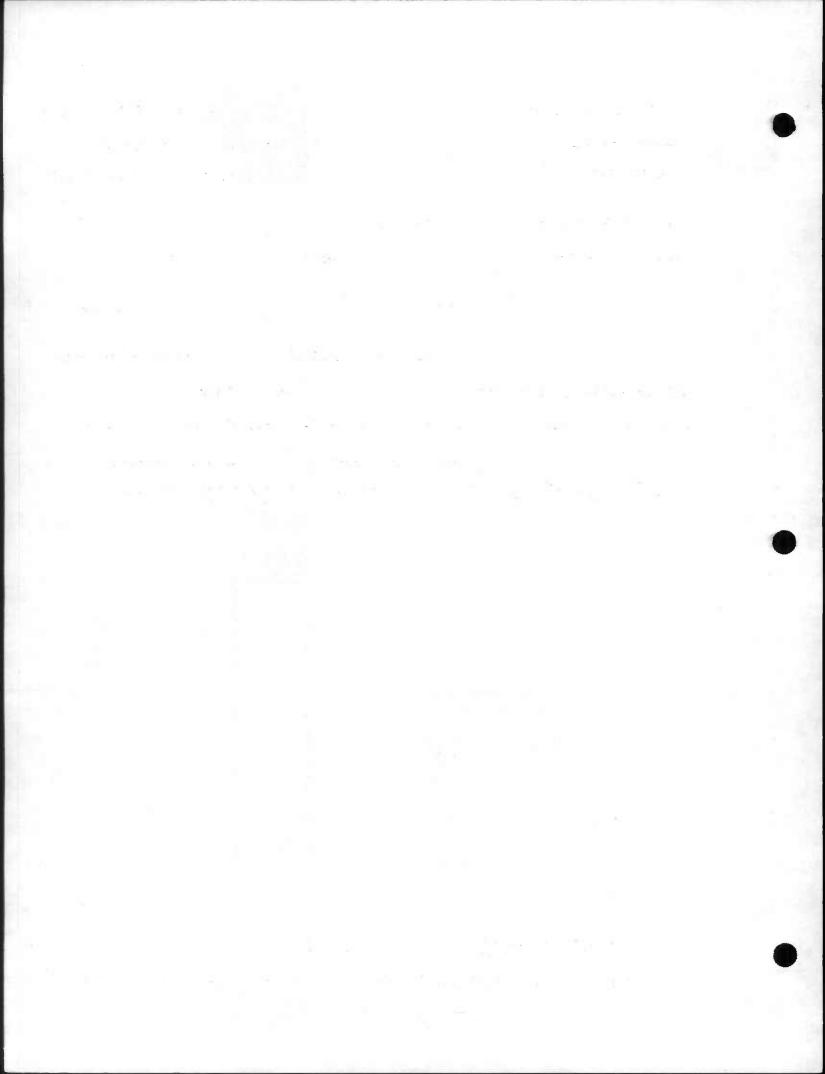
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State of Maryland / Department of Health and Mental Hygiene

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) Willis E. Brewbaker 4a. Facility Nema (If not institution, giva street end numbar) Manor Care—Wheaton 1. Decedent's Name (First, Middle, Last) April 16, 19 4c. County Manor Silver Spring Montg	
Willis E. Brewbaker April 16, 19 4a. Facility Nema (If not institution, giva street end numbar) Manor Care—Wheaton April 16, 19 4b. City, Town, or Location of Deeth Ac. County Montg	3. Time of Death
Manor Care-Wheaton Silver Spring Montg	99 12 Noon
Table 1	ot Death
	gomery
Funeral Director 5. Social Security Number 180-12-7945 6. Sax 1 M 2 F 7. Aga (In yrs. last birthdey) 75 Yrs. 75 Yrs. 75 Yrs. 75 Yrs. 75 Yrs. 8. Deta of Birth (Month, Day, Year) Sep. 10, 1923	9. Birthplace (State or Foraign Country) Pennsylvania
Usuei Residance of Dacedant	10d. Inside City Limits
10a. Stata 10b. County 10c. City, Town or Location	12 Yas 2 No
Maryland Montgomery Rockville 10e. Street and Number 10c. City, Town or Location Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizan of W	
10e. Street and Number 10f. Zip Code 10g. Citizan of W	vriat Country?
14424 Brad Drive 20853 USA 11. Marital Stetus 12. Wes Decedant Evar in U,S. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-	e - Amarican Indian,
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3 Widowed 4 Divorced Year or Dates: WW II 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working) 16b. Kind of Bu	White usiness/Industry
15. Decedant's Education (Specify only highest grada complated) Elamentary/Secondary (0-12) 5+ Electrical Engineer Federal	
	Government
The state of the s	
William McKinley Brewbaker Celia Baer 19a. Intormant's Name/Balationship (Type, Print) 19b. Mailing Address (Street and Number of Bural Bouts Number City or Town	
17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumam United S	State, Zip Code)
William McKinley Brewbaker 19a. Intormant's Name/Ralationship (Type, Print) Margaret J. Brewbaker (wife) 20b. Place of Disposition (Name of Dete 20c. Location-	20853
20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other placa) 20c. Location -	City or Town, Stata
4 Donation 5 Othar (Specify) Cedar Lawn Cemetery 4/20/99 Hagersto	wn, Maryland
Margaret J. Brewbaker (wife) 14424 Brad Drive Rockville, Maryland 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - 1	inc.
500 University Blvd., W., Silver Spr. 23a Penti. Enter the dismission or complications that caused the daeth. Do not antar the mode of dying, such es cardiac or raspiratory arrest, shock, or half to be presented by the cause on each lina.	ing MD 20901
Medical Immediata Causa (Final disaasa or condition Con yestwe Cardrony upatty	Intarval Batween Onset and Death SEVENUL URLEY
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Due to (or as a consequence of): Due to (or as a consequence of):	
Cause. Enter Undarlying Cause. Colsaasa or injury that initiated events rasulting in daath) Last Due to (or as e consequence of):	
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Solution of the second of the	atribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
S Signe at 1 by 1 by 1 by 1 by 1 by 1 by 1 by 1 b	[
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To the control of the	
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25. Was case reterred to medical axaminer? 1	ed
= Cary Int 2DACCIdati	er or Rural Routa Number,
27. Mannar of Death 2	
Solicide Solici	nner as steted. and due to tha causa(s)
29a. Cartifiar (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa number 20c. Chy or Town, Stata) Chy or Town, Stata) Chy or Town, Stata) Chy or Town, Stata) Chy or Town, Stata) Chy or Town, Stata) Chy or Town, Stata) Chy or Town, Stata) Chy or Town, Stata) Chy or Town, Stata) Chy or Town, Stata) Chy or Town, Stata) Chy or Town, Stata) Chy or Town, Stata)	and due to tha causa(s) if (Month, Day, Year)
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29a. Cartifiar (Check only one) 29a. Cartifiar (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Date signed	and due to tha causa(s) if (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 16, 1999 Year Emilie B. Bishop 12:50 AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Manor Care-Bethesda Bethesda Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Months Days 1 M 201 F 99 Yrs. 578-01-6105 Washington, D.Q March 24, 1900 Usuel Residence of Decedent 10b. County 10c, City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2904 N. Leisure World Blvd., #216 20906 United States 12. Was Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grant Bishop Mary Koch 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20906 19a. Informant's Name/Relationship (Type, Print) Mary F. Keyhoe/ Niece 2904 N. Leisure World, #216, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) April 21, 1999 20a. Method of Disposition 20c. Location - City or Town, State 1 2 Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue M00689 Bethesda, Maryland 20814-3501 dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting In death) Cerebral Thrombosis 2 Days Due to (or as a consequence of) Cerebral Vascular Disease years Due to (or as a consequence of): Cerebral Arteriosclerosis years Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b, Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy

Physician /Medical Examiner Examiner

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To the Hospital or within 24 hours aft To the Funeral Di completaly filled in

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Pages 1 and 2 should be filed within 72 hours after death with the Manyland nation of Health and Mental Hygiene.
Intil if Item 27 Is marked other than "naturel", or Items 23s or 23s-f show many or other traumatic event, ma Medical Exeminer must be notified at my or other traumatic event, ma Medical Exeminer.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical 1 Yes 2 X No 27. Manner of Death 1 XNatural 5 Pending Investigation 2 Accident

28a. Date of Injury (Month, Dey Year) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital:

28b. Time of

eth (Item 23e) (Type, Print)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28d. Describe how Injury occurred

29e. Certifier

30 Name

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s)

29b. Signature and title of

Blaine Fitzgerald, M.D.

person who completed coding

6 Could not be

29c. License number D-01948

29d. Date signed (Month, Day, Year)

April 16, 1999

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

State

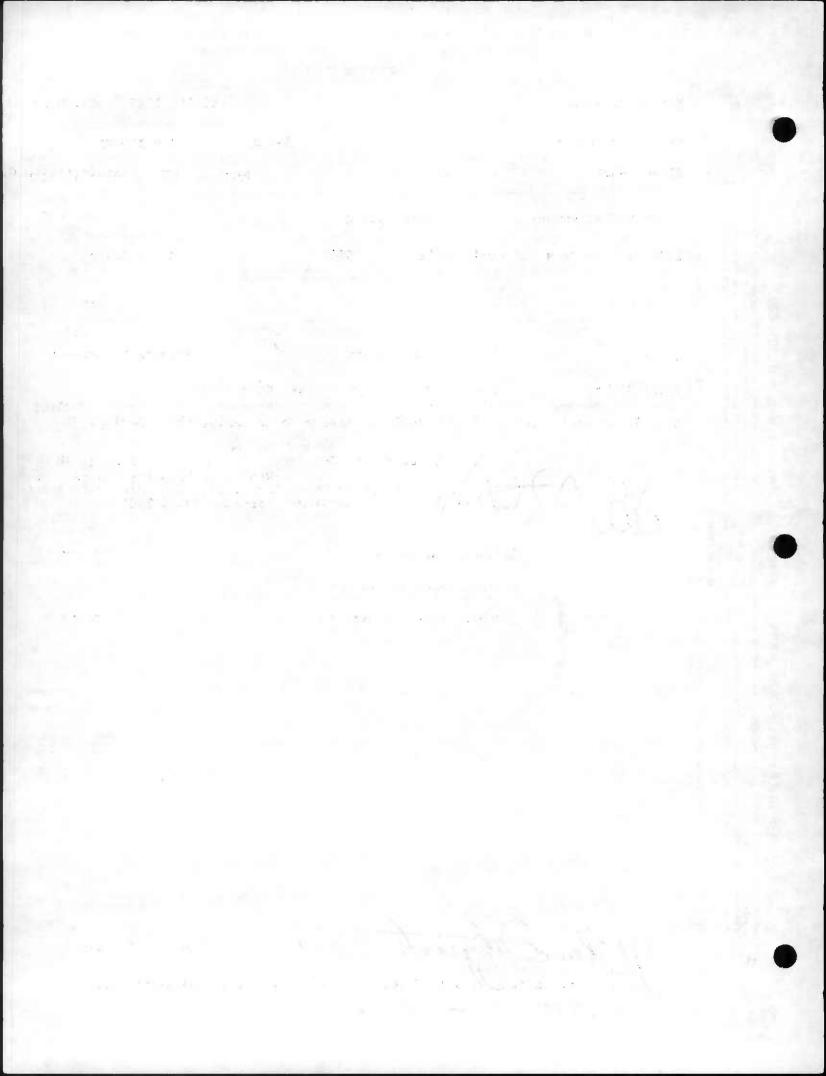
Registrar

8218 Wisconsin Avenue, Bethesda, Maryland 20814 32. Registrar's Signature

DHMH 16 Rev 6/95

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. The or Attanding Physician:

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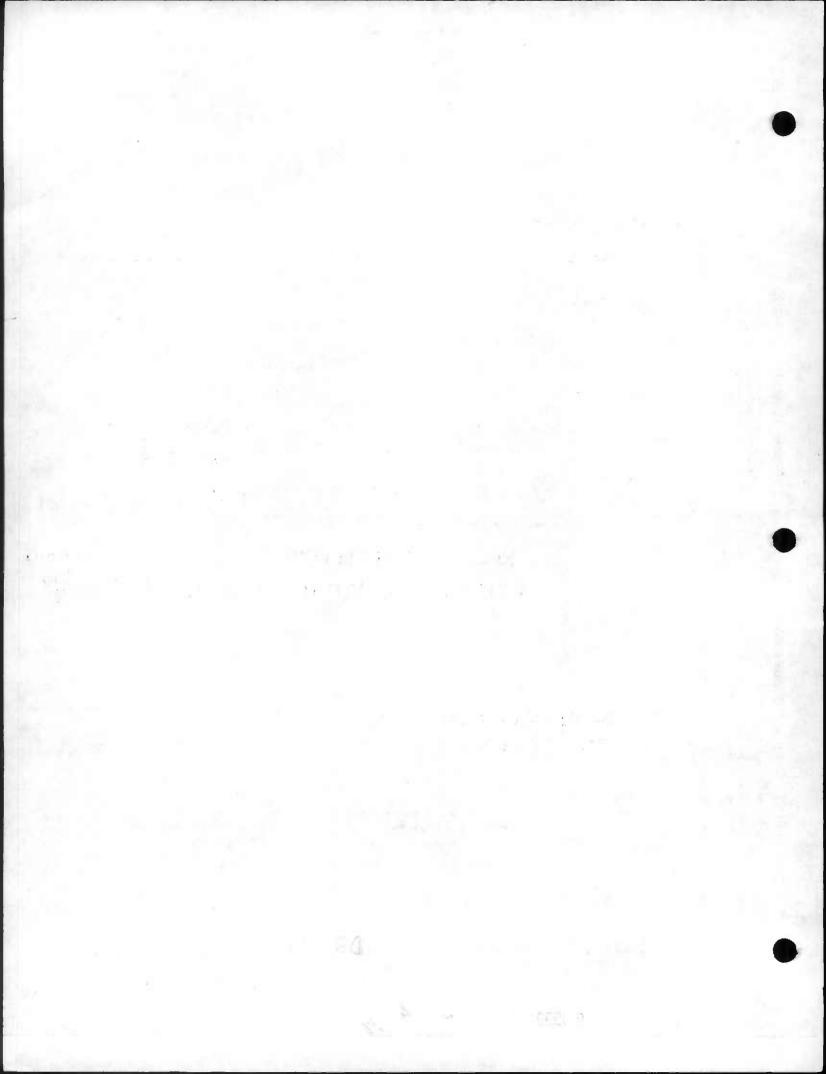


State of Maryland	/ Department of Health	and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev Year **Physician** Norma Lifson Berkeley 18, 1999 April 4:10 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 8818 Tallyho Trail Potomac Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplece (Stete or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Months Hours 1 □ M 2 💢 F Yrs. 132-14-4357 72 Director May 17, 1926 New York Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "naturel", or flems 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? filed within 72 hours after death with Hyglene.

ther than "naturel", or flems 23a or 20854 8818 Tallyho Trail United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Bleck, Whita, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Baitimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: à 3 Widowed 4 X Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) .. Pages 1 and 2 should be filed wi tment of Health end Mentai Hyglen tant: If item 27 ie marked other th jury or other treumatic event, the 6 Professor Community College 17. Fether's Neme (First, Middle, Last) 18 Mothar's Neme (First, Middle, Maidan Surname) Be P Michael Lifson Clara Kaufman 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 29 Douglass Street, San Francisco, CA Jonathan E. Berkeley 94114 (son) 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. Chesapeake Crematory 4-19-99 Beltsville, Maryland 21. Signetura of Funeral Service Licensee 22. Name end Address of Fecility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 23a. Pert1. Enter the disease, or complications thef caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediete Cause (Finel Four hours diseese or condition resulting in death) Examiner Examiner rebrovascular accident physician and s the burial-transit tha death certificate be executed Sequentially list conditions, if any, leading to immadieta cause. Enfer Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ Records, The law requires 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? Completed CUPITIC STENOPUS has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vitai Attending Physicien: director. Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only ona) Hospitel: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manyfer of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Panding investigation After 1 Natural n 24 hours efter death.

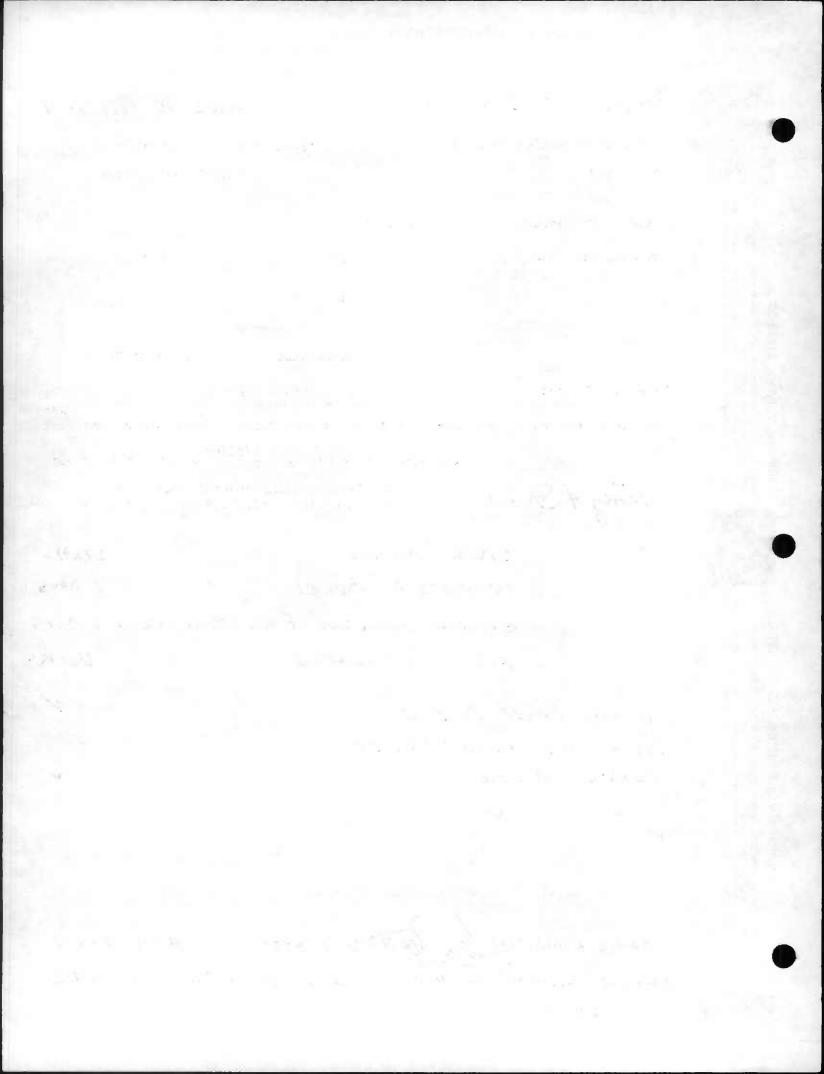
Ne Funeral Director: After pletely filled in by the fun 1 TYes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 ☐ Homleide ò Hospital edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the tima, data and place, and due to tha cause(s) and menner as stated. To the Hosp within 24 hos To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D2588 what April 19, 1999 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) Joann Urquhart, M.D., 9711 Medical Center Drive, #300, Rockville, MD 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar 19 1999



				State of M	Maryland		artment rtificate			nd M		giene 9 Reg. No.	14	490
H	Physiciar	1	1. Decedant's Nama (First, Middle, Last)	BASS	SFORE	,		B			2. Data of De Month APRIL	Day	Yaar 1999	3. Tima of Death
	/Medica Examine		4a Facility Nama (If not institution, give s Washington Advent:						akoma	Pai	cation of Daat	4c. Count	ty of Death	
	Funeral Director		5. Social Security Number 458-18-2969 Usual Residence of Decedant	M 250 F	Aga (In yrs. la:	st birthday) Yrs.	Months	Days Days	If Undar 2	4 Hrs. Min.	8. Data of Bir (Month, Da Oct. 28	th ly, Year)	9. Birthp Coun Texa	olaca (State or Foreig otry)
	vith the Meryland or 28a-f show		10a. Stata 10b. County Maryland Worceste 10e. Street and Number	er		Town or Lo	City 10f. Zip	Code				10g. Citizan of		0d. Inside City Limit: 1 ☐ Yas 2 ☑ No htry?
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Division of	eath. or: After thi		27. Manner of Death 1 Matural 2 Accidant 3 Suicide 6 Could not be datamined	28a. Data of In (Month, I	Injury - At hom	28b. Time o Injury	М			10	28d. Dascribe	how injury occi	urred	al Route Number,
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_			SAMIR R-NG 30. Name and address of person who co SAMIR R. NGI	AT, M	death (Itam	23a) (Type,	Print) PRRO	LA	tv. 7.	AKO	MA PA	RK, M	0,2	0912

State Registrar

31. Date filed (Month, Day, Year) APR 2 0 1999



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month Day Yaar Baccio Bacci 15, April 1999 0910 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Talbot The Memorial Hospital Easton 8. Data of Birth (Month, Day, Year) Feb 26, 19 If Undar 1 Yaar If Undar 24 Hrs. 6. Sax. 1☐M 2☐ F 5. Social Sacurity Numbar 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Months Days Hours Min. 577-64-7857 84 Yrs. Italy Usual Rasidence of Decedant 10c. City, Town or Location 10a. Stata 10b. County 10d. Insida City Limits 1 □ Yas 2 □ No Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g, Citizan of What Country? 1702 Brannocks Neck Rd 21613 USA 14. Race - Amarican Indian, 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yas 2♥ No If Yas, Giva Was Decadant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) Black, Whita, atc. 1 Navar Marriad 2 Marriad 1 ☐ Yas 2√ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elementary/Secondery (0-12) Collega (1-4or 5+) Illustrator Architecture 5+ 18. Mother's Name (First, Middla, Maidan Sumema) 17. Fathar's Nama (First, Middla, Last) Oreste Bacci Emma Camici 19b. Mailing Addrass (Straat and Number or Rurel Routa Numbar, City or Town, Steta, Zip Coda) 19a. Informant's Name/Ralationship (Typa, Print) 1702 Brannocks Neck Rd, Cambridge, MD 21613 Clelia B. Bacci/Wife 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Date 1 Buriai 2 Cramation 3 Ramoval from Stata Gate of Heaven Cemetery | Apr 20 4 Donetion 5 Other (Specify) Silver Spring, MD 22. Nama and Addrass of Facility Hines-Rinaldi Funeral Home 21. Signatura of Funaral Sarvice Licensas 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listony one cause on each line. Approximete Intarval Batween Onset and Death Immedieta Causa (Final disaase or condition rasulting in daath) Altheroscherotic heart clineare 4east dialyon dependent years reval disease Sequantially list conditions, if any, laading to immadiata ceusa. Enter Underlying Causa (Diseese or Injury that initiated avants rasulting in death) Last year Dua to (or as a consequence of): Hun extension 40000 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara eutopsy findings available prior to 24a. Was an autopsy performed? complation of causa of death? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Wes cesa rafarrad to medicel axaminar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ► ER/Outpatient 3 ☐ DOA 1 Yes 2 No Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Other (Specify) 28a. Deta of Injury (Month, Day Year) 27. Mennar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding invastigation 1 Natural 2 Accidant 1 ☐ Yas 2 ☐ No 6 Could not be datarminad 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

physician end s the buriel-transit The law requires that the death certificete be executed attending ph signed by the a is certificate hes b director, page 2 sl this After this deeth.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

? is marked other than "natural", or items 23a or traumatic event, the Medical Examinar must be a

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "n any injury or other traumatic event, as Med BAGE.

Physician

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Physician/Medical

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Certification:

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72 hours after death

Baltimore, Maryland 21215-0020

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Director: /

Box 68760. P.0. Division of Vital Records. or Attending Physician: To the Hospital or A within 24 hours effer To the Funeral Direcompletely filled in b

3 Suicida 4 ☐ Homicida 29e. Cartifian (Check only one) 29b. Signatura and titla of certifiar

30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print)

Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. Licansa number

D46020

29d. Data signed (Month, Day, Year)

99

Syed I. Ali 506 Idlewild Ave, Easton, MD 21601

Registrar

31. Data filed (Month, Dey, Year) APR 19 1999 32/Registrar's Signatura

10

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Directo

Physicia /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deeth.

To the Funeral Director: After this cartificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for usa as the buriat-trensit

Division of Vital Records, P.O. Box 68760,

Malik Batson

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

14493

		Malik	Batso	o n					April	17.	Yeer 1 9 9	9 9.	21p.
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The Memor	rial Ho	ospital				E	asto	n		Ta	albot		
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Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

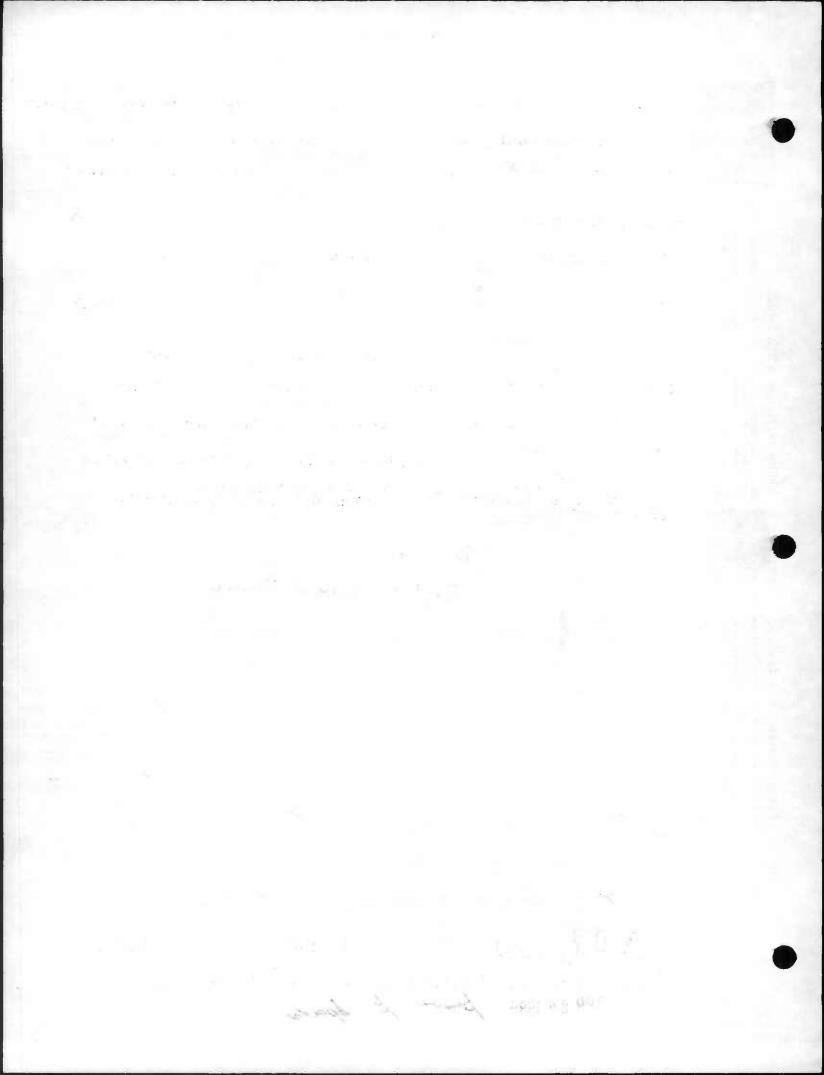
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r: Air	2 ☐ Accident invastigation			М	1 🗆	Yas 2	No					
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fille fille	29a. Cartifiar 1M Certifying P	hysician: To the best of	my knowledga, daa	th occurred a	t tha ti	ma, data a	nd place	end due to the	cause(s) end ma	annar es st	ated.	
within 24 hours after deem. To the Funeral Director: After complataly filled in by the funer Medical Certification:		miner: On the basis of a	axamination and/or									
Me appe	29b. Signeture end title of certifier	A state of state		290	Licens	sa number			29d. Data signe	d (Month. I	Day, Year	
8 - 8	Los. digital did dille di conditei	14/1. 11	1			005			April			
	muchael	(XII)							VALTI	10,	1000	
	30. Nama and addrass of person who	completed cause of de	ath (Itam 23a) (Type	e, Print)								
	Michael Lees, M.D	. , 219 S.	Washingto	n.Stre	er.	East	ton.	Maryland	21601			
State	31. Date filed (Month, Day, Year)		's Signature	B. 1	100	us.						
Registrar	APR 2 2	וששש			-							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Deeth 1. Decedent's Nama (First, Middla, Last) Month 16,1999 **Physician** 1:00A.M. **Blake** April Bernice Edwina /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner Corsica Hills Nursing Home Centreville Oueen Annes | Hondar 1 Yaar | Hondar 24 Hrs. | 8. Deta of Birth (Month, Dey, Year) | Aug. 12, 1931 9. Birthplaca (Stata or Foraign 7. Aga (In yrs. last birthday) 5. Social Sacurity Number **Funeral** 1□ M 2XF Yrs. Maryland 67 Director 220-26-1460 Usual Rasidance of Dacedant with the Merylend 10a, Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be nortified at 1 Yes 2 No Director Maryland Ridgely Caroline 10f. Zip Coda 10g. Citizen of What Country? 10e. Street end Number USA 21660 11917 Central Ave. Funeral death 12. Was Dacedent Evar In U,S. Armed Forcas? Was Dacedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian. permit. Peges 1 and 2 should be filed within 72 hours efter of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumetic event, trained of Exercising Pages. 1 ☐ Yas 2 No If Yas, Giva Yeer or Detes: 1 □ Nevar Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: p 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elementery/Secondery (0-12) College (1-4or 5+) Line Inspector Cannery 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fethar's Nama (First, Middla, Last) Be Thomas Bernice Acree 2 Clarence. 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 6652 Laurel Grove Rd., Denton, Maryland 21629 James T. Acree, Sr. (nephew) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4/24/99 DentogMaryland 4 ☐ Donetion 5 ☐ Othar (Spacify) Spring Grove Cemetery 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Bennie Smith Funeral Home P.O.Box 1687, Easton, Maryland 21601 23a P.m. Foliar lie and lase, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory errest, though one causa on each line. Approximeta Intarval Batween Onset end Daeth **Physician** liviedical Immedieta Causa (Final disaase or condition resulting in death) Diabuter Examiner Dua to (or es e consequence of): New Direce Examiner 5 have physician end the buriel-trensit the death certificate be executed Sequantially list conditions, if any, laading to immadiata ceuse. Enter Underlying Causa (Diseasa or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequance of) Physician/Medical Dua to (or es a consaquence of): 80 for use es 23b. Did tobecco use contribute to the ceuse of death? ed by the s deteched i Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown p 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? certificate has 21710 1 ☐ Yas 2 Dalo or Attending Physician: director, 25. Was cesa rafarred to medicel axaminar? Be 26. Placa of Deeth (Check only one) Hospital: Othar: 4 Aursing Homa 5 Rasidance 6 Othar (Specify) 10 1 Yas 2 No 1 Inpatiant 2 ER/Outpatiant 3 DOA this funeral 27. Menner of Death 28d. Dascribe how Injury occurred 28b. Time of 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? Certification: Naturel 2 Accidant 5 Pending efter death. Director: Aft 1 Yes 2 No investigation 6 Could not be 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide To the Hospital of within 24 hours er To the Funeral D Certifying Phyelcien: To the best of my knowledge, deeth occurred at the time, dete and place, and dua to the ceuse(s) end menner as steted.

Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and mannar stated. 29a. Cartifier Medical 29d. Data signad (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number 137036 from Chok my 2/6/9 30. Name and addrass of person who completed ceuse of death (Itam 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 15, Byberg April 1999 6:15 pm 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth Westminster Nursing & Rehabilitative Center Westminster Carroll | H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth (Month, Dex., Year) | Aug 7, 1917 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign Months M 2□ F Minnesota 81 Yrs. 10c. City, Town or Location 10d. Inside City Limits Baltimore 1⊠Yes 2□No 10f. Zip Code 10g. Citizen of Whet Country? 3109 Mary Avenue 21214 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) College (1-4or 5+) Boiler Mechanic Gaf 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Tina Korsvei 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Darlene A. Dorsey, POA 1563 Brehm Rd, Westminster, Md 21157 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete

4/16

934 South Main St, Hampstead, Md 21074

Eline Funeral Home

Hampstead, MD

29d. Date signed (Month, Dey, Year)

Physician

/Medical

Examiner

Funeral

Director

28a-f ahow

Director

Funeral

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Completed

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7 is marked other than "natural", or itams 23s or 28s-f sho traumatic event, the Medical Expressment must be notified at

pemit. Peges 1 end 2 should be filed within 72 hours after death with 'Depertment of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or

Baltimore, Maryland 21215-0020

the Maryland

Harold

10b. County

1 ☐ Buriel 2X Cremetion 3 ☐ Removel from State

4 ☐ Donetion 5 ☐ Other (Specify)

21. Signeture of Funeral Service Licenses

5. Sociel Security Number

424-30-5501

10e Stete

Maryland

11. Marital Status

10e. Street end Number

Usual Residence of Decedent

3₺ Widowed 4 Divorced

Elementery/Secondary (0-12)

12

20e. Method of Disposition

Iver Byberg

Physician /Medical Examiner

The lew requires that the death certificate be executed physician a for use es signed by the e certificate hes b irector, pege 2 s director, nours effer deeth.

neral Director: After this of filled in by the funeral di within 24 hours e To the Funeral C completely filled

Division of Vital Records, P.O. Box 68760,

or Attanding Physician:

To the Hospital

Immediate Cause (Final disease or condition		mvun			Interval Between Onset and Deeth
resulting in deeth)	b. alshin	(or es e consequence o			34
Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest	COPD	(or es e consequence o			157
Pert II. Other elgnificent conditions con	ntributing to death but not re	sulting In the underlying	ceuse given in Pert I.	23b. Did tobacco uee co	intribute to the cause of death?
				24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth?
25. Was cese referred to medicel				1 ☐ Yes 2 🗷 No	1 ☐ Yes 2 ☐ No
examiner?	Hospitel: 1 ☐ Inpatient 2 ☐	☐ ER/Outpetient 3☐ [Other	eeth <i>(Check only one)</i> Home 5 ☐ Residence 8 ☐ Oth	ner (Specify)
27. Menner of Deeth 1 Naturel 5 Pending 2 Accident Investigetion	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury et Work?	28d. Describe how Injury occur	
3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	nome, ferm, street, fectorify)	ory, office	28f. Location (Street end Numb City or Town, Stete)	ber or Rurel Route Number,
29e. Certifier (Check only one) Certifying Physical Examination (Check only one)	scien: To the best of my knier: On the besis of exemine end menner stated.	owledge, death occurre etion end/or Investigation	d et the time, date end plec on, in my opinion, deeth occ	ce, end due to the ceuse(s) end me curred et the time, date end plece,	enner es steted. and due to the cause(s)
20h Signature and title of contillar		2	On I langua austral	and Detections	data the David Maria

29c. License number

Carroll Cremations

23e. Pant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest,

22. Name end Address of Fecility

Registrar

APR 1 9

29b. Signeture and title of certific

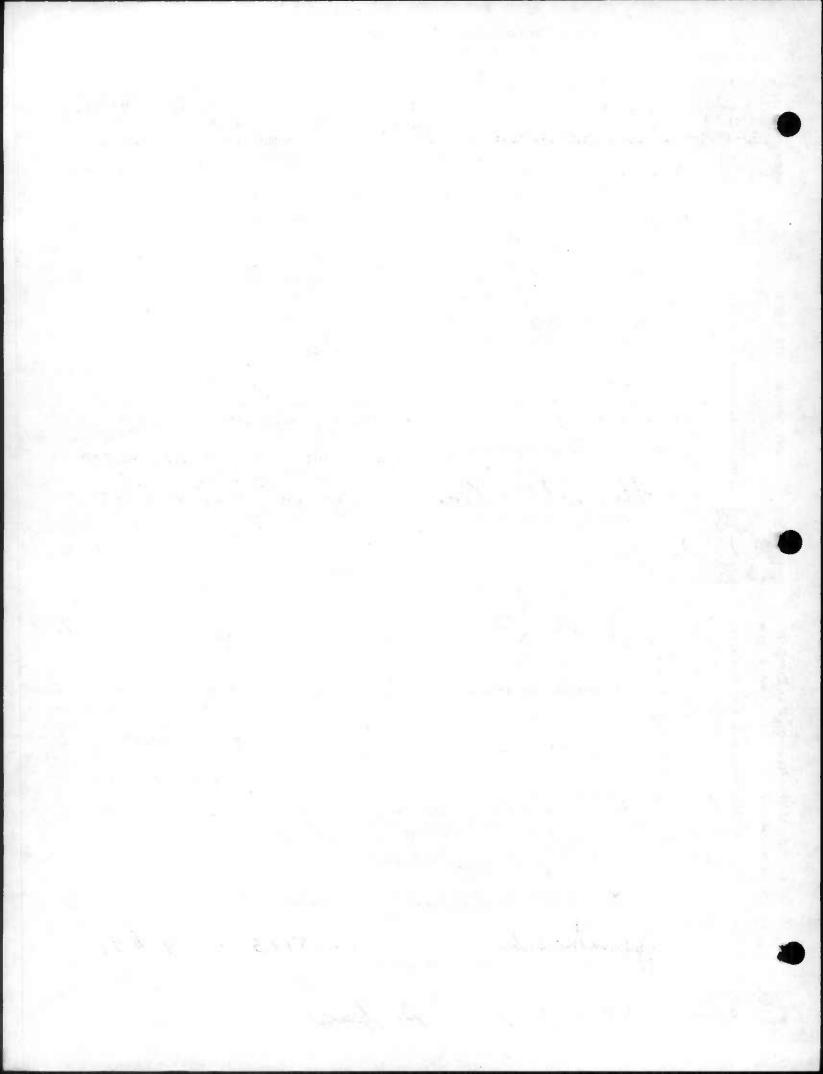
31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Sparker

John Middleton MD, 1130 Baltimore Blvd, Westminster, Md 21157



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Elizabeth W. Buddemeier April 1:00AM 19 1999 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Annapolis If Under 24 Hrs. Hours Min. It Under 24 Hrs. (Month, Dey, Year) (Month, Dey, Year) (Month, Dey, Year) (Month, Dey, Year) (Maryland) Anne Arundel Medical Center Annapolis If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1□M 201F Months Deys Yrs. 83 213-03-7472 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Anne Arundel Annapolis 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 51 Amos Garrett Blvd. 21401 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 14. Race - American Indien. Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 ☐ Never Married 2 ☐ Merried Specify: white 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary/Educater Anne Arundel County 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) H. Henry Wilking Lillian May Reid 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Purel Route Number, City or Town, State, Zip Code) Mary L. Buddemeier (daughter) 525 Murdock Rd. Baltimore, MD 21212-2021 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Buriel 2 Cremation 3 Removel from State Parkwood Cemetery 4/23/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility John M. Taylor Funeral Home, Inc. 21. Signeture of Funerel Service Liamese 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death cute myocaracdial Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): 23b. Did tobacco use coptribute to the cause of death? Pert II. Other eignificant conditions contributing to deeth but not resuming in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 Yes 201 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 1 Impatient 2 ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 1 M Naturel 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

requires that the death certificata be executed P.O. Box 68760, The law cartificate has or Attending Physician: this After s efter death.

ettending physician and for use es the burial-transit 8 pege 2 should funerai

Physician

/Medical

Examiner

Director

Funeral

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Director

item 27 is marked other than "natural", or items 23s or 28a-f show other traumatic event, the Medical Examinar must be notified at

2 should be filed within 72 hours after ond Mental Hygiena. Is marked other than "natural", or its

permit. Peges 1 end 2 sh Department of Health end Important: If Nem 27 Is m any Injury or other traun pnce.

Physician

/Medical Examiner

Examiner

Physician/Medicai

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Certification:

edical

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(Check only one)

29b. Signature and little of cegitte

29a. Certifier

altimore, Maryland 21215-0020

with the Meryland

death v

Division of Vital Records, filled in by To the Hospital o within 24 hours of To the Funeral D completely

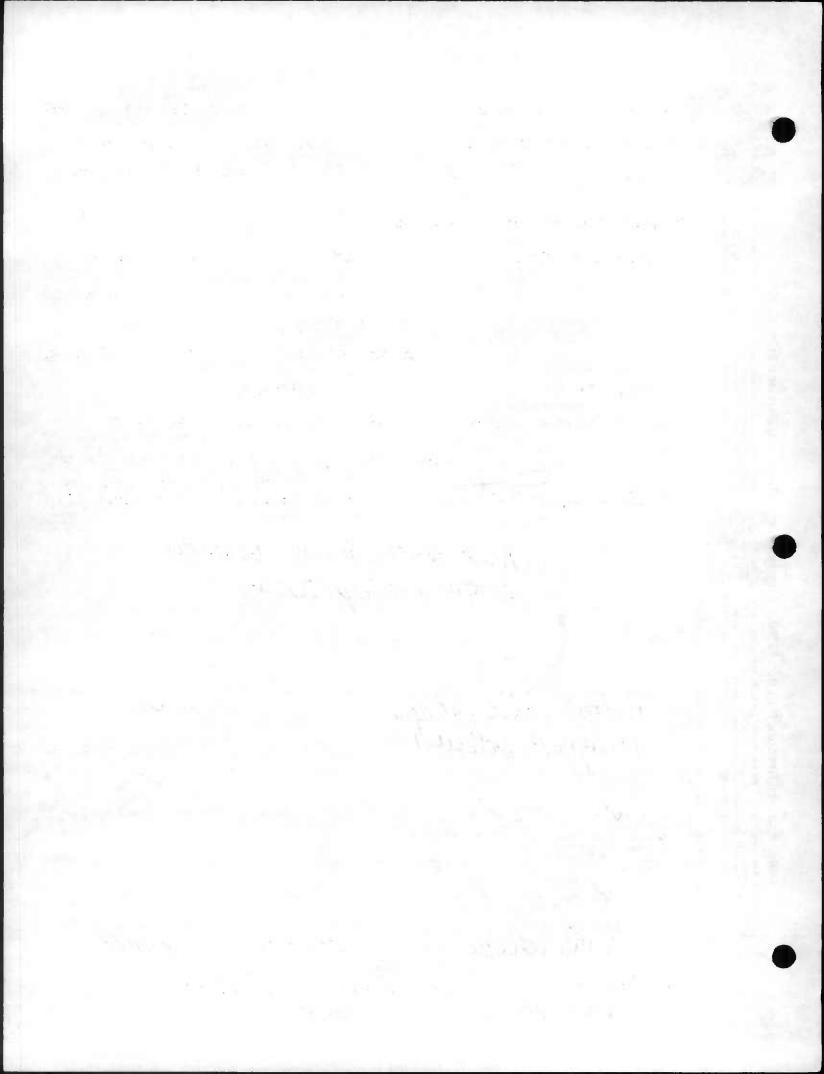
30. Name end a dress of person who completed cause of deeth (ttem 23e) (Type, Print) Jack Lichtenstein, MD 207 Ridgely Ave. Annapolis, Maryland 21401 32. Registrar's Signeture 31. Date filed (Month, Dey, Yeer) APR 21

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

29c. License number

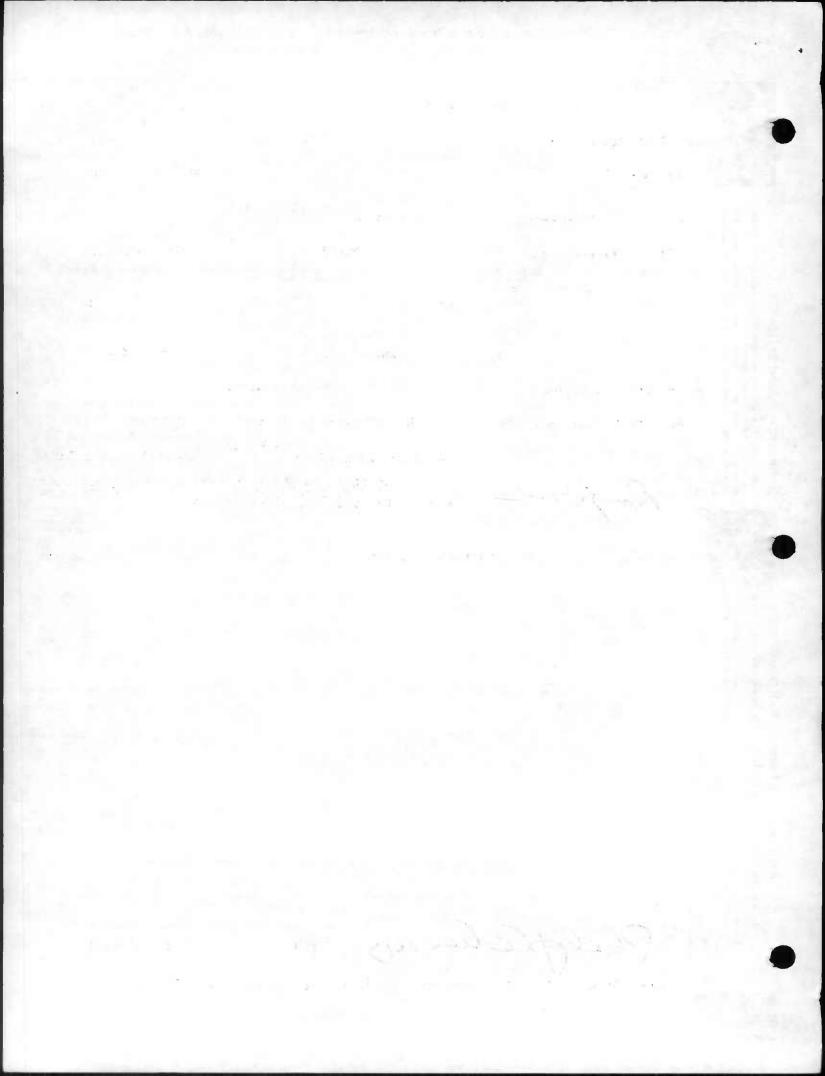
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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					Cert	tificate	of Death			Reg. No.	1 4 4	.5 ()
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hysician /Medical		Warre	en Cramer	Colc	ney			A	pril	16, 199	3:	35 PM
xaminer	4e Fecility Name (If not in	stitution, give	street and number;				4b. City, Town		ion of Death			
	7304 Millv	-					Bethes				gomery	
neral ector	5. Social Security Number 452-34-6606 Usual Residence of Deced	1(XM 2 F	90 (In yrs. 69	last birthday) Yrs.	If Under 1 Y Months D		Min.	Date of Bir (Month, Da ept. 2	th y, Year) 25, 1929	9. Birthplace Country) Flori	(State or Foreign da
SCAL SCAL		County		10c. Cit	y, Town or Loc	ation					10d. lr	nside City Limits
To To	Maryland M	ontgon	nery		Bethe	esda					1	☐ Yes 2 No
inere 239 of 2841 should be notified at Funeral Director	10e. Street and Number 7304 Millwo	ood Roa	ad	1		10f. Zip Co 208				10g. Citizen of United	What Country?	113
Darlos In	11. Marital Status 1 Never Mamed 2 3 Widowed 4 D		12. Was Decedent Armed Forces? 1 XYes 2 If If Yes, Give Year or Dates:	No	1	/as Decedent Yes, specify ☐ Yes 2 ☑	of Hispanic Origin Cuban, Mexican, P No Specify:	? (Specify Puerto Ric	y Yes or No en, etc.)	- 14. Re- Ble Specif	ca - American Inck, White, etc.	
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umatic event, the To Be Co	17. Fether's Name (First, I	Aiddle Leet	5+	_	Co	nsulta		Neme /F	iret Middle	Consul		6.00
traumatic event,	Herndon P.		0.17				Mary				,	
To	19a. Informant's Name/Re				10h Mailine	Address /S	treet and Number of			er City or Town	State Zin Cod	(a)
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any injury	21. Signature of Funeral S		100	M0019	Ro 7	Name and A bert A 557 Wi	ddress of Feculity Pumphresconsin a, Maryl	ey Fi Aveni	ineral	L Home/I	Bethesda Chase	-Chevy
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se es the buri	that initiated events resulting in death) Last	J	d	Due to (o	r as a consequ	ience of):						
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omp									1 🗆	Yes 2⊠ No	1 ☐ Ye	s 2 No
director director	25. Was case referred to rexaminer? 1 □ Yes 2 ☒ No	-	Hospital: 1 ☐ Inpati	ent 2 🗆	ER/Outpatient	3□ DOA	26. Place of Other: 4 \(\text{Nursi} \)			one)	her (Specify)	
nera	2 Accident	Pending investigation		ry Year)	28b. Time of Injury	M 28c.	Injury at Work? 1 Yes 2 No			how injury occu		
completely filled in by the funeral Medical Certification:	3 Suicide 6 4 Homicide	Could not be determined	28e. Placa of In building, e	jury - At hi c. <i>(Specif</i>	ome, farm, stre	et, factory, of	ffica	28f	. Location (City or To	Street and Num wn, State)	ber or Rural Ro	ute Number,
pletely fill	(Check only 2 M		raician: To the best Inar: On the basis of and manner st	f examina		estigation, in	my opinion, death			date and placa	, and due to the	cause(s)
E Som	296. Signature and of	Certifien	Sol	ie	ay		oc 7600				ed (Month, Day, 19, 1999	
> ' '	¥	1										
> ' '	30. Name and address of Philip Cohe	~					V Washing			20007		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Tima of Deeth Month 04 COLLINS 1428 NAYME 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) NNAPOLIS ANNE RUNDER (Anne Arundel Medical Center) 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplaca (State or Foreign Country) If Under 1 Yaar Months Days 5 Social Sacurity Number 7. Aga (In yrs. last birthday) Days 1 M 2XX Hours 413-28-5597 95 Tennessee Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City. Town or Location 1 XYes 2 No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 1713 Lingamoor Lane U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? 1 Yas 2 Who If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: White XXXWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Sam Vawter Captola Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alice Taylor - Daughter 1713 Lingamoor Lane Annapolis, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/17/99 Rose Hill Cemetery Humboldt, TN 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or neer feilure. List only one ceuse on each line. Approximata Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, laading to Immadiate cause. Enter Underlying Cause (Diseese or Injury that initiated avents resulting in daath) Last Due to (or as a consequanca of) 23b. Did tobecco use contribute to the cause of death? Part II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

ブム Baltimore, Maryland 21215-0020 **Physician** /iviedical Examiner

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Hospital or Attending Physician:

that the death certificate be exec

Division of Vital Records, P.O. Box 68760

injury or

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10a State

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item 27 is marked other than "natural", or items 23s or 28s-1 ehow other traumatic event, the Medical Examinat must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after deeth Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23.

with the Meryland

Examiner Physiclan/Medical the 68 esn jo by 8 Completed director, Be 10 funerel Certification:

6 Could not be

1 ☐ Yes 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No

25. Was case referred to medicel examiner? 1 Yes 2 No 27. Manner of Death

1 Inpatient Date of Injury (Month, Day Year) 5 Pending investigation

2 ER/Outpatient 3 □ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Location (Street and Number or Rural Route Number City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident 3 Sulcide

4 Homicide

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as steted.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. Licansa number 21438 29d. Data signad (Month, Day, Yaar)

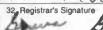
AVESTE 120 ANNAPOLIS Md 21401

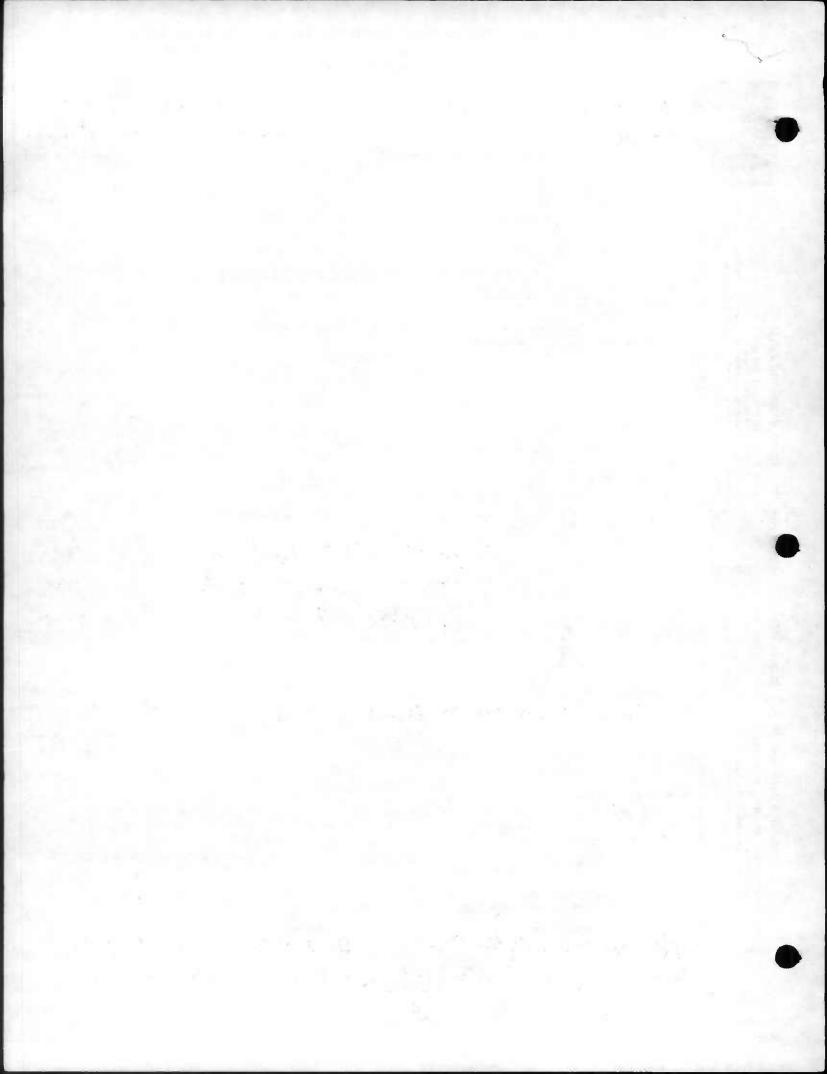
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Medical

31. Date filed (Month, Day, Yeer)

1999 APR 19





State of Maryland / Department of Health and Mental Hygiene 9 1450

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A Donesion S Dohes (Speech) Montgomery Crematorium, Inc. Bethesda, Maryland 20. Signature and Exercises Service Learning Service L	of H of H or oth	,		Removal from St.	20b. Pl	ece of Dispo metery, cre	osition (Neme of metory or other p	ece) Apri	1 23. 1	999	20c. Location -	City or To	own, State
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D01120 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Walter E. Goozh, M.D. 1299 Lamberton Drive, Silver Spring, MAryland 20902-3411 State 31. Date filed (Month Dey, Year) 32. Registrer's Signeture	lospil t hour uner uner		1 Certifying Ph	ysician: To the be	est of my know	vledge, deat	h occurred et the	time, date en	nd place, end du	e to the co	euse(s) end m	enner es s	stated.
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